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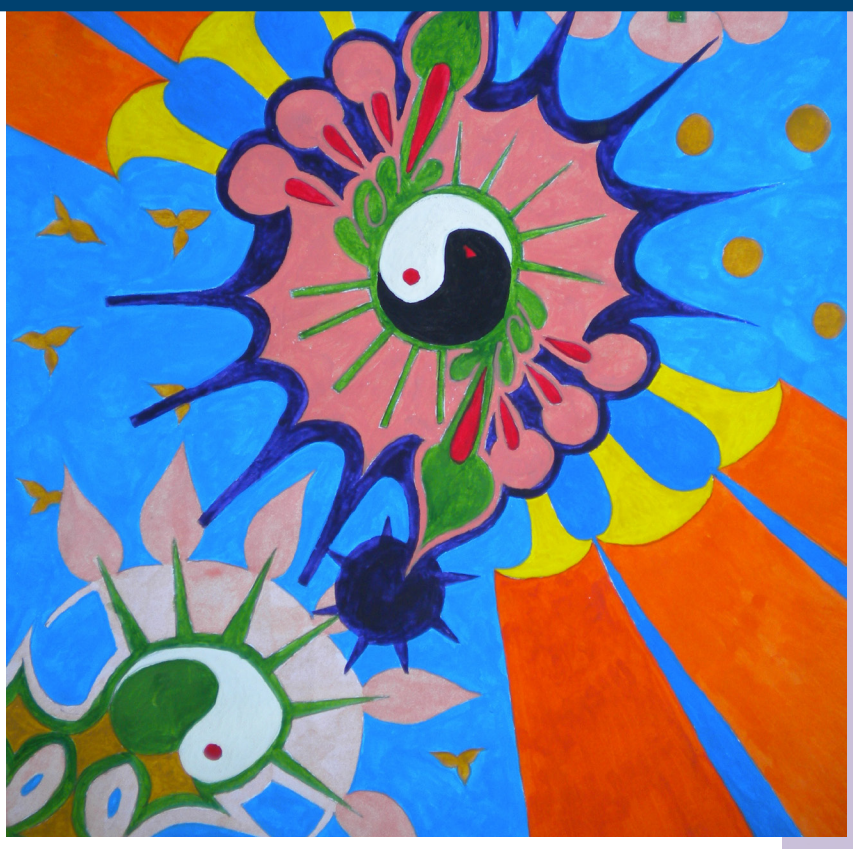
TAY

CULTURAL RELEVANCE

Full Service Partnership Tool Kit



California Institute for Mental Health

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Preface

Full service partnership (FSP) programs were designed under the leadership of the California Department of Mental Health in collaboration with the California Mental Health Directors Association, the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, mental health clients and their family members, mental health service providers, and other key stakeholders of the mental health system. Although in existence since 2005, full service partnership programs are continuing to develop the distinguishing characteristics that lead to good outcomes for mental health clients and their families.

The FSP Tool Kit is intended to provide FSP supervisors and team members with written guidance to support ongoing development of programs and integration of practices. This publication series encompasses a Tool Kit for each age group — children, transition-age youth, adults, and older adults — in recognition of programmatic differences that exist across the four age groups.

Preface (cont'd)

The Tool Kit has numerous unique characteristics that include:

- Development with close involvement of diverse, statewide advisory committees that represent all of California's public mental health constituents, including clients, family members, counties, and mental health service providers.
- Identification not only of service delivery models for age-specific full service partnerships, but also an overview of practices that can be integrated into full service partnerships.
- Reference and access to website links that offer additional in-depth information on the majority of practices included in the Tool Kit.
- Recommended resources to assist in the ongoing development of full service partnership programs that support clients in their recovery.

Acknowledgements

This Tool Kit is dedicated to all the people with lived experience, children and their families, transition-age youth, adults, or older adults, who continually demonstrate their belief in possibilities. This project was funded through California's Department of Mental Health (DMH). Creation of this Tool Kit resulted from the ideas, experience, and suggestions from many groups and people throughout California. Advocates committed to the improvement of services for ethnic and cultural minority communities, and participants from the statewide advisory committee, age-specific committees, and the performance measurement subcommittee demonstrated tireless dedication to ensure a practical outcome. Representatives from all 58 counties — through county departments, regional networks, partner agencies, and community-based agencies — participated via meetings, conference calls, and interviews.

Additional appreciation is extended to the staff and consultants at the California Institute for Mental Health (CiMH) for their excellent leadership and compassionate guidance in this visionary endeavor.

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Opposites Attract by **John Michael Byers**; among the artist's first colored (watercolor) pieces, created during recovery from a co-occurring disorder (2008–2009)

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Terminology

We appreciate that no one term may fit the same situation. The writers also realize that one term does not convey the same meaning across all age groups. However, to facilitate the writing of this project, selection of only one expression for certain concepts became necessary. We thank the committee members who, for the sake of clarity, helped guide us through this process.

For example, we designated the term “client” as the universal identifier for an individual with lived experience, even though we acknowledge that the term “consumer” or “person” may be more common in some areas or in some groups. Exceptions to this selected term may be found throughout the text if written within a direct quotation.

Configuration of health and mental health services with sensitivity to the needs of multicultural communities has been variously termed “cultural competence,” “cultural responsiveness,” and “cultural relevance.” This portion of the FSP Tool Kit series is titled “Cultural Relevance” to reflect the intent and spirit of our approach. Specifically, we hope that the

Terminology (cont'd)

tools in this document will assist county programs and providers in offering the best possible care to minority clients – care that reflects the values and beliefs of the culturally rich and diverse communities that form the fabric of the state of California, care that is culturally relevant. Although the term "cultural relevance" is used most frequently in this document, it is used interchangeably with "cultural competence" and "cultural responsiveness."

Introduction

This Full Service Partnership Cultural Relevance Tool Kit was created as part of a series of documents designed to provide training and technical assistance to counties implementing full service partnership programs. The first component in the series, the FSP Philosophies and Practices Tool Kit, offers practical guidelines for implementation of FSP programs with particular attention to promoting practices that embody the guiding principles of the Mental Health Services Act (MHSA). The current Tool Kit expands on that foundation by focusing on the principle of cultural relevance espoused in the MHSA essential elements. This Tool Kit presents guidelines and practical tools to assist counties and providers in improving the quality of and access to care for unserved, underserved, and inappropriately served ethnic and cultural groups.

The Cultural Relevance Tool Kit is meant to be used in conjunction with the Philosophy and Practices Tool Kit for a particular age group.

Background

California continues to lead the nation in ethnic and cultural diversity, with approximately 57% of the population identifying as ethnic minorities. Of the minority population, 37% are Hispanic or Latino (any race); 13% Asian; 6.2% African American; 1% Native American; 4.9% multiracial; and 0.4% Native Hawaiian or Pacific Islander.[1] Given the demographics of this state, mental health providers and mental health organizations must be prepared to meet the needs of dynamic, culturally rich, and diverse client communities.

Disparities in Mental Health and Mental Health Services

Ethnic minorities constitute a significant portion of the population in need of services, yet receive fewer mental health services and poorer quality care[2] than other population segments. California estimates for 2007–2008 indicate that the widest disparity in access to care existed for Hispanics and Latinos; the prevalence of severe mental illness for the Hispanic and Latino population was estimated at 560,000 individuals, but only 150,000 received mental health services (a discrepancy of approximately -73%). Discrepancies also existed for Native Americans (-59%), Asians (-51%), non-Latino Whites (-26%), and African Americans (-13%).

Disparities in quality of care are more difficult to document; however, research suggests that ethnic minorities are less likely to receive evidence-based treatments;[3] more likely to receive services in restrictive and punitive settings (such as inpatient psychiatric institutions, child welfare departments, and criminal justice settings;[4] and are exposed to institutional and provider racism and

1 U.S. 2010 Census. (2010). U.S. Census results: California. Retrieved from http://2010.census.gov/2010census/data/index.php

2 California Department of Mental Health. (2007–2008). Statistics and data analysis: Retention and penetration rate data. Retrieved from http://www.dmh.ca.gov/Statistics_and_Data_Analysis/RetentionPenetrationData.asp?county=Statewide&view=View#county

3 U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity – A supplement to mental health: A report of the surgeon general.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Retrieved from http://www.surgeongeneral.gov/library/mentalhealth/cre/sma-01-3613.pdf

4 Snowden, L. R., Hastings, J., & Alvidrez, J. (2009). *Overrepresentation of black Americans in psychiatric inpatient care. Psychiatric Services, 60*(6), 779–785;
U.S. Surgeon General. (2001). Mental health: Culture, race, and ethnicity.

discrimination.[5] These disparities in type of care provided explain to some degree the disproportionate use of mental health services by African Americans; although penetration rates indicate that this group is served more than others, African Americans obtain much of their care through involuntary services (as inpatients) or involvement in child welfare services and criminal justice.[6]

This research on quality of care does not take into account grassroots efforts to counteract these disparities through culturally relevant approaches to mental health care for communities of color. However, with minimal financial and infrastructure support, these grassroots activities are hampered in their ability to counteract deficits in the mainstream mental health system and, consequently, disparities persist. The emergence of interest in community-defined practices represents an effort to recognize and empower local, community-driven programs that respond to disparities in access and quality of care.

Organization of the Tool Kit

This Tool Kit presents guidelines, practical suggestions, and approaches to improving quality of care and access to care for multicultural communities.

Cultural competence is defined as the *"ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs*"[7] and involves competence or abilities in three areas: 1) multicultural knowledge, 2) awareness, and 3) skills. The first, multicultural knowledge, suggests that providers should have specific knowledge about the demographic makeup, history, traditions, customs, values and beliefs, and language of the cultures of the groups they serve. Second, providers should be aware of their own cultural heritage; the ways in which their cultural values, practices, beliefs, and worldview differ from those of others; their biases and assumptions; and the ways in which their worldview affects

5 National Research Council. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care.* Washington, DC: The National Academies Press.
6 Snowden, L, Hastings, J., & Alvidrez, J. (2009, June). *Overrepresentation of black Americans in psychiatric inpatient care. Psychiatric Services 60*(6), 779–85. doi:10.1176/appi.ps.60.6.779;
U.S. Surgeon General. (2001). Mental health: Culture, race, and ethnicity.
7 Betancourt, J. R., Green, A. R., & Carrillo, J. E. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches.* New York, NY: The Commonwealth Fund.

the clinical encounter. Finally, providers must possess a range of therapeutic and communication skills to be flexible and to be able to alter the therapeutic approach based on cultural differences.

The California Brief Multicultural Competence Scale (CBMCS) is based on cultural competence theory and expands the tripartite model of cultural competence to include the following domains: 1) multicultural knowledge, 2) awareness of cultural barriers, 3) sensitivity and responsiveness to consumers, and 4) sociocultural diversities. These categories are linked to specific training topics in the CBMCS curriculum. The first three categories resemble and expand upon the original tripartite model. The fourth category focuses on the interaction of membership in various marginalized groups, including lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ), veterans, and persons with physical disabilities.

The FSP Cultural Relevance Tool Kit emphasizes an applied approach to a specific area of service provision: full service partnerships. This emphasis on the application of theory is evident in the inclusion of a wide variety of "implementation strategies" for each tool. Because of this functional emphasis, an organizing framework based on both cultural competence theory and the CBMCS structure culminated in five categories, including one focusing on specific mental health programs and practices for ethnic and cultural minorities.

Accordingly, borrowing from both the cultural competence literature and the CBMCS, the organizing framework for the FSP Cultural Relevance Tool Kit includes the following domains:

- Domain #1: Multicultural Knowledge
- Domain #2: Cultural Barriers to Care
- Domain #3: Cultural Self-Awareness
- Domain #4: Sociocultural Diversities
- Domain #5: Specific Practices

The CBMCS domains that focus on four major ethnic groups – African American, Asian/Pacific Islander, Latino, and Native American – form the structural basis for

this Tool Kit. Because this Tool Kit was written with inclusiveness in mind, many of its components are applicable to ethnic and cultural populations in addition to these four groups.

This Tool Kit is based upon three major resources:

1. FSP Advisory Committee recommendations in conjunction with subcommittees associated with each age group and community-defined practices.
2. Cultural competence theory, scholarly studies, and research literature.
3. The California Brief Multicultural Competence Scale, Multicultural Reader and Training Manual.

Domain #1

Multicultural Knowledge

The Multicultural Knowledge domain contains tools to build understanding of the culture of groups and individuals served. It encourages knowledge of: (1) specific ethnic and cultural groups, their worldview, language, cultural norms, values, attitudes, beliefs, and behaviors; (2) clients' ethnic and cultural identification, the extent to which clients share the views of their community, and how individuals within a community may differ; and (3) social, historical, and political forces that influence a specific ethnic or cultural group, such as racism, discrimination, exposure to war, immigration trauma, and historical oppression.

Creating a Cultural Formulation

Purpose

To assist FSP teams in developing a framework for assessing and serving clients and families from different cultural and ethnic backgrounds. This framework will enable a more effective partnership to be established between the team and the client, and will permit application of more effective interventions and supports.

Definition

The DSM-IV-TR[8] provides a comprehensive outline for *creating a cultural formulation* that consists of the following elements:

Cultural identity of the individual. Understand the perspective of the client and his or her family regarding ethnic and cultural affiliations, and the degree of involvement or affiliation with the client's culture of origin and the host culture.

8 American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (4th ed., text revision). Washington, DC: American Psychiatric Association.

Definition (cont'd)

Cultural explanations of the individual's illness. Understand from the perspective of the client and his or her family what they consider the source of the mental illness and how they characterize it.

Cultural factors related to the psychosocial environment and levels of functioning. Understand from the perspectives of the client and family members how they view psychosocial stressors and what they regard as support, including social and familial support, and the role of religion or spirituality, if any, in the client's life.

Cultural elements of the relationship between the FSP team member(s) and the individual. Identify differences among the client, family, and FSP team member in culture, ethnicity, language, social status, age, gender, or sexual identity, and assess the impact those differences may have on engagement, relationship development, and treatment.

Overall cultural assessment for diagnosis and services. Conduct an overall assessment of how the preceding cultural considerations may affect diagnosis and service delivery.

Implementation Strategies

- Adopt a respectfully curious approach in obtaining the information to create the cultural formulation. Providers should avoid making assumptions and instead should focus on asking questions to elicit information and begin building a relationship.
- Consider consulting with a cultural broker when a significant difference in the culture of the provider and the client exists.
- Acknowledge where cultural differences exist, and discuss the ways in which these differences affect the client's ability to form a strong working relationship with the provider.
- Create a template or form outlining the elements of the cultural formulation.
- Apply the cultural formulation as the basis for understanding the client from his or her perspective.
- Utilize the cultural formulation in understanding how clients express and explain physical and emotional symptoms of concern.

In conjunction with completion of the cultural formulation as part of the assessment and treatment planning process, consider using client- or person-centered treatment planning that is developed in alignment with client values and goals. Developing an understanding of clients based on how they view themselves — rather than based on stereotypes or cultural assumptions about a clients' treatment preferences — will enhance the success of treatment. Some clients may wish to include their family in the treatment planning process, while others may defer to the expertise of the treatment team to devise prescriptive treatment planning and goal identification. Allowing the client to make that decision is entirely consistent with a person-centered treatment planning process.

Understanding Ethnic-Specific Protective Factors and TAY Identity Formation

Purpose

To assist providers in identifying, recognizing, and incorporating cultural strengths and assets into assessment and treatment planning, and to promote a positive ethnic identity in TAY clients.

Definition

Understanding ethnic-specific protective factors requires familiarity with the culturally embedded qualities that can buffer against negative experiences and enhance resiliency and well-being in TAY clients. These qualities include positive ethnic identity, strong and constructive relationships with family members, and cultural traditions and ceremonies that play a role in *TAY identify formation.*

Implementation Strategies

- Evaluate the client's protective factors as part of the cultural formulation and overall assessment. Explore community, family, and individual factors that contribute to resilience.
- Conduct community mapping activities to identify ethnic-related resources, faith-based communities, and cultural arts and sports activities.
- Connect youth to potentially helpful organizations, individuals, and other community resources that promote exploration of ethnicity and connection to cultural traditions and heritage. Such resources include:
  - Ethnic and culturally based community centers such as La Raza or Native American Health Centers.
  - Elders, clan leaders, big brothers or sisters.
  - Activities (e.g., ethnic festivals and events, and traditional celebrations).
- Emphasize the use of expressive arts such as hip-hop, poetry, digital storytelling, painting, rap, and youth music in learning about and celebrating different cultural traditions and experiences.
- Consider using films such as *Knowing Who You Are* or books such as *Parrot in the Oven: Mi Vida* by Victor Martinez and *Farewell to Manzanar* by Jeanne Wakatsuki Houston and James Houston to elicit discussion and exploration of ethnic identity development.
- Offer workshops and group discussions that encourage young adults to explore and express their identity through art, music, and other media (e.g., collages, poetry, Adobe PowerPoint presentations, photography, or film).
- Provide a space for LGBTQ youth when discussing issues around developing a sense of self, including sexual identity, ethnic identity, and the intersection of these identities.

Acculturation

Purpose

To understand the impact that adjustment to a new culture exerts on clients and families.

Definition

Acculturation refers to the process of cultural change that takes place when an individual from one culture comes into contact with a new culture. Acculturation may involve changes in language spoken, behaviors, customs, and values. It often entails changes in the person's affiliation to his or her culture of origin, as well as adoption or rejection of elements of the new culture. Research has suggested that people who are able to retain a sense of connection to their culture of origin while adopting elements of the new culture (a bicultural orientation) tend to have better outcomes.

Implementation Strategies

- Assess the level of acculturation of the client, child, and family. While the level of English language acquisition often is used as a proxy measure for acculturation, a more accurate picture of a person's acculturation status may be obtained by using an acculturation questionnaire.
- Be aware that the level of acculturation of the client and family members may affect their understanding of mental illness and its causes, their willingness to seek services and disclose information about emotional problems, their interest in seeking alternative and complementary treatments, and their understanding and acceptance of psychotherapy and psychiatric interventions. Be respectful of differences in acculturation as well as alternative views of mental illness and treatment.
- Gather information about the client's culture of origin and the ways in which the client's family and community traditionally respond to mental illness. Explore the current views of the client and family regarding mental illness.
- Assess the social environment of the client and family. Do they engage with other people who have similar cultural views and experiences?
- Support development of positive ethnic identity. This may entail helping clients explore their sense of self, their family history, their relationships with their parents and/or their children and grandchildren, and their values and beliefs.
- Recognize that the process of acculturation may be a significant source of stress. Stressors related to acculturation may include loss of one's community and social network; changes in socioeconomic status and resulting financial stress; loss of structure and activity in daily life; and loss of meaningful social roles (Miller, 1999). Support clients and/or families

Implementation Strategies (cont'd)

in managing this stress by assisting them in identifying coping strategies. These strategies may be as simple as learning to ride the bus or use an automated teller machine, or as complicated as understanding the changes in cultural values that create conflict within families as family members acculturate differently.

- Assess for acculturation conflicts within families. For example, in many families children adopt a new language as well as new cultural values, beliefs, and behaviors more quickly than their parents do. The resulting cultural differences between parents and children can be a source of stress and conflict. Similarly, in many families – particularly immigrant and refugee families – older adults who live with extended family members may have different levels of acculturation, which may cause conflict. Working with these clients entails being sensitive to these cultural conflicts and assisting family members in communicating and accepting each other's values and beliefs.
- Recognize that differences in family members' acculturation levels may result in disagreement regarding treatment strategies and goals. Be prepared to manage this conflict in a respectful and collaborative manner that takes into account cultural roles and expectations.

Social Determinants of Mental Health – (Socioeconomic Status)

Purpose

To help FSP teams recognize the impact of social conditions on clients and/or families, and to integrate strategies to address social concerns in treatment planning.

Definition

The conditions in which people live and work, including poverty, unemployment, neighborhood violence, racism, and discrimination, are among the *social determinants of mental health.* These indicators of *socioeconomic status* have an immense impact on mental health. Ethnic minority communities in the U.S. have greater exposure than mainstream populations to adverse social conditions; they are more likely to be poor, to experience inequities in employment opportunities, to be exposed to violence, to experience poor health and health-care access, and to be the victims of racism and discrimination. For many

Definition (cont'd)

mental health clients, these conditions play a critical role in the development and course of psychiatric illness as well as responsiveness to treatment. Mental health providers can deliver effective treatment for such clients only after becoming aware of the extent to which these factors contribute to clients' mental illness, and take appropriately responsive actions. Fortunately, the "whatever it takes" philosophy central to FSP programs provides mechanisms for responding to these conditions.

Implementation Strategies

- Assess the social and economic environment of the client and/or family, and explore the implications of these social conditions for the family and for the client's recovery.
  - What is the level of financial stability of the client and the family?
  - Is the client or caregiver unemployed and if so, is this a source of stress?
  - Are the client and family exposed to adverse neighborhood conditions such as violence, prostitution, delinquency, or drug use and selling, and if so, what is the impact of this exposure?
  - Do the client and family have access to parks, grocery stores, playgrounds, libraries, medical treatment, transportation and other resources?
- Explore the impact of poverty, if present, on the client and/or family. In addition to the stress of financial instability, poverty may cause isolation, exclusion, stigma, and shame.
  - Do the client and family have sources of social support – friends and extended family?
  - Do the client and family feel involved in and part of the community?
  - How do the client and family cope with poverty?
- Scrutinize the impact of racism and discrimination on the client's mental health and well-being, and incorporate strategies in the treatment plan to confront their effects. Experiences of racism and discrimination may influence the client's mental health directly (e.g., through direct acts of violence and by causing fear, anxiety, stress, feelings of isolation, and anger) as well as indirectly (e.g., by limiting the client's ability to access resources).

Implementation Strategies (cont'd)

- Establish a safe environment in which care providers, clients, and families can discuss social conditions. Acknowledge the influence of these social conditions in mental illness, and recognize that clients and family members may be uncomfortable talking about matters that pertain to social inequities and racism. Some clients may respond most favorably to care providers of the same ethnic and/or cultural background.
- Broaden discussions of interventions to include strategies to deal with poverty, violence, and racism. Discuss ways in which the client could feel safer and more connected to the community.
- Recognize the role of providers as advocates and partners, and engage in activities to promote improved social conditions for clients. Doing so may include assisting in local activities to improve neighborhood conditions, and educating the staff about inequities in social conditions that affect local communities.
- Initiate emergency and temporary financial resources when possible and appropriate. FSP programs allow flexible expenditure of funds in a broad array of service activities, including those that can respond to inadequacies in housing, employment, access to health care, or other unfavorable social conditions.
- Connect clients with employment assistance agencies, legal aid, refugee services, and other community agencies that can help resolve social and economic problems. Ensure follow-through by assisting clients in navigating other systems.
- Ensure that the staff has easily accessible up-to-date information regarding local resources and social service agencies. Schedule monthly "field trips" to local service agencies as a means of encouraging staff members to establish connections with them.

Implementation Strategies (cont'd)

- Co-locate mental health programs, whenever possible, with health or social service agencies, and coordinate care across social service sectors.
- Develop scattered site housing options in safe, yet affordable areas to avoid creating highly concentrated housing in unsafe areas where illegal activities may be prominent.
- Consider how the experiences of clients with serious mental illness – including psychiatric hospitalization, incarceration, and homelessness – affect the team's engagement strategies, cultural formulation, and service planning.
- Recognize that field-based services and subsidized transportation are essential for clients at or below the poverty level.

Understanding Cultural Variations When Making the Transition to Adulthood

Purpose

To educate and sensitize providers to cultural variations that can influence the transition process to adulthood. Also, to encourage providers to be aware of possible cultural bias in FSP outcome measures and milestones, such as independent living, employment, education, and marriage.

Definition

Developmental milestones such as moving out of the parental home, getting married, and obtaining a job are viewed differently across cultures. In some ethnic groups, children are expected to stay home until they are married and to take on adult responsibilities (e.g., providing care for siblings, cooking, or contributing financial support) or to get married earlier than in the dominant European American culture. *Understanding cultural variations when making the transition to adulthood* requires providers to be aware of cultural

Definition (cont'd)

norms within the youth's family and community, as well as variations among individuals and in the community. Such consideration will help youth cope with their transition to adulthood. Questions to consider include:

- What is considered normal in the youth's culture and community?
- Are the expectations of the youth and family different from those of their community or of the dominant culture?
- Do expectations differ depending on the youth's gender (e.g., are girls expected to marry earlier than boys, or contribute to household upkeep or caregiving more than boys)?

Implementation Strategies

- Review and discuss FSP outcome measures regarding employment, income, housing, and education with TAY clients and their families to determine what is culturally congruent for them.
- Explore and research different cultural expectations and traditions (such as rites of passage), and incorporate those considerations into the transition process whenever appropriate. Be aware that milestones such as getting married and leaving the home may vary widely among cultures. For example, in traditional Hmong and rural Mexican cultures, girls normally marry earlier (during the teenage years) than in dominant U.S. culture.
- Consider consulting with a cultural broker or expert to gain more information on cultural norms and traditions related to coming of age.
- Be aware that in many cultures, teenagers and young adults are expected to play a significant role in running the household. This expectation may conflict with mainstream depictions of teenage responsibilities, and youth may find themselves negotiating these conflicting expectations. Assist youth in coping with the task of reconciling different cultural expectations. (While respect for cultural views is critically important, this does not mean that providers should accept family expectations that are exploitative or abusive. If FSP team members disagree with the family's expectations, consult with a cultural broker to identify ways to bridge this gap or to resolve situations that are unacceptable.)
- Invite families to share their cultural traditions and expectations for becoming an adult.
- When appropriate, acknowledge and celebrate culturally defined milestones and outcomes such as quinceaneras.
- Establish relationships with ethnic-specific community resources, attend community events, and invite community providers to FSP team meetings when appropriate.

Using Complementary and Alternative Treatments

Purpose

To understand the role of complementary and alternative healing practices in response to mental health problems in ethnic and cultural minority communities. To assist FSP teams in working effectively with clients who rely on or are interested in alternative healing practices.

Definition

Use of complementary and alternative treatments encompasses practices, interventions, and services that are not part of the conventional health or mental health system. While some of these treatments such as nutritional supplements, meditation, and prayer are common across groups, some are tied to specific spiritual beliefs. For example, Native American sweat lodge ceremonies, Hmong shaman practices, and Mexican curanderismo incorporate spiritual practices. Complementary and alternative practices may be performed by shamans, sobadores, curanderos, and spiritual leaders of various faiths.

Implementation Strategies

- Build staff capacity to work effectively with clients who utilize alternative treatment practices by:
  - Working with cultural brokers and community leaders to identify and connect with local providers of alternative treatments.
  - Building relationships with alternative treatment providers based on mutual respect and collaboration.
  - Increasing staff awareness and understanding of complementary and alternative practices by sponsoring workshops and by offering other opportunities to learn about practices and connect with local providers.
- Work with clients in:
  - Exploring the role of alternative and complementary practices with them and with families.
  - Ensuring that the treatment team is well informed regarding the rationale, process, and potential outcomes of the particular treatment in order to integrate a treatment plan with a specific complementary or alternative practice that a client and family requests.
  - Collaborating with alternative treatment providers to ensure coordination of care, and avoid conflicting approaches to treatment by sensitively and respectfully exploring the possibility of merging traditional Western medical treatments with alternative treatments that the client practices.
- Build capacity within communities to enable complementary and alternative treatment providers to become part of provider networks utilized by FSP programs. The process may include fostering relationships between community providers and organizations with supportive infrastructure, and conducting workshops to teach community providers how to build relationships with county agencies, facilitate knowledge exchange, and assist alternative care practitioners in navigating county system requirements.

Developing Knowledge of Populations Served: History and Culture

Purpose

To assist FSP teams in developing an awareness of the various communities served and an understanding of the culture of these communities.

Definition

County mental health departments typically serve a culturally diverse population. Providers can improve the effectiveness of their services by *developing knowledge about populations served: history and culture.* Understanding of the cultural values, traditions, beliefs, behaviors, religion, and worldviews of clients, as well as historical events that are relevant to them, can help optimize interactions with them.

Implementation Strategies

Identifying groups served

- Collect and disseminate detailed information identifying the groups served and the languages spoken. Census data and threshold language data can be a starting point for identifying and gaining understanding of each of the ethnic groups served in a particular county.
- Gather additional important data from cultural brokers, community-based agencies, and faith-based organizations that serve clients. Knowledge of the size and distribution of Hmong, Russian, Palestinian, Somalian, and other populations that are not reflected in U.S. Census categorization may be crucially important in some counties. By interviewing key cultural leaders and representatives of community-based organizations (CBOs), county service agencies may develop a more comprehensive awareness and understanding of such cultural and ethnic groups.

Developing Knowledge

- Work to gain a basic understanding of the history of the ethnic groups served and the obstacles they face.
- Ask each client for a history of important events in his or her life. Include questions about experiences of racism and discrimination, immigration history and trauma, and stories about relationships between the client's culture and other relevant cultures.
- Train the staff to research each client's country of origin. Discuss with the client the tentative understandings you have gained from your research, and seek clarification, corrections of misinterpretations, and elaboration.

Implementation Strategies (cont'd)

- Study major events and experiences to which members of the agency's cultural clientele may have been subjected.[9] Clients and conditions to consider may include:
  - African Americans – history of slavery and ongoing racism and discrimination.
  - American Indians – loss of land, genocide, elimination of spiritual beliefs supplanted by missionaries' beliefs, and coerced integration.
  - Asian Americans and Pacific Islanders – economic privation, taxation imposition, concentration camps, forced labor, and government policies that excluded Japanese and Chinese.
  - Hispanics and Latino Americans – wars for independence, American occupation, immigration and corresponding policies, and fear of deportation.
  - Examine the history of racism in the United States and the different types of racism that clients of different age groups experience. For example, older adults may have been exposed to more overt forms of racism, such as violence, harassment, and hate crimes, while younger clients may experience more subtle and covert racism sometimes described as "racial microaggressions"[10]

9 Der-Karabetian, A., Dana, R. H., & Gamst, G. C. (2008). *CBMCS multicultural training program: Participant workbook* (pp. 13, 14). Thousand Oaks, CA: Sage Publications.
10 Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation.* Hoboken, NJ: John Wiley & Sons, Inc.

Implementation Strategies (cont'd)

- Recognize that individuals from some cultures are more likely than others to suffer from post-traumatic stress disorder due to exposure to war-related violence. Affected cultures include those originating in Southeast Asian countries, Central America, and some African countries. Clients also may undergo immigration trauma resulting from rape, other forms of violence, or exposure to harsh environmental conditions during the immigration journey.

Understanding the Role of Biological, Extended, and Client-Identified Families

Purpose

To be aware of the importance of family members in the client's life and recovery process, to understand family norms, expectations and traditions, and to understand the TAY client's attitudes about family culture and participation in treatment.

Definition

Understanding the role of biological, extended, and client-identified families is often an important step in building a successful collaboration for the ethnic youth. Many TAY struggle to separate and individuate, and experiment with different roles and counter-cultures. The young adult's cultural background and sense of family obligations may exert a strong influence on the TAY's transitional goals.

Implementation Strategies

- Consult with a cultural broker or expert when working cross-culturally, to gain an understanding of expectations regarding family roles. Cultural brokers may offer insight into the traditional ways in which family members communicate, the ways in which parents discipline their children, how families divide work responsibilities, and the behavioral and role expectations for men, women, and children within the family.
- Ask TAY clients about their family, during the initial engagement and assessment process. Questions may include:
  - Who does the youth consider members of his or her family?
  - Does the TAY client wish family to participate in treatment and recovery planning?
  - Is the presence of family members appropriate while conducting an assessment? Remember, in some cultures, inclusion of family members in these interactions may be considered inappropriate or may make the TAY client feel uncomfortable. Work with the family and client to develop a plan for assessment that ensures that clinical goals are achieved while respecting the family's cultural expectations.
- Determine with whom the client lives and what changes in the living situation may occur. Is the client expected to move out of the home or stay with family until marriage or other milestones are reached?
- Respectfully inquire about the financial expectations of the TAY client.
  - Is he or she expected to be self-supporting financially? If so, by when?
  - Is the TAY client required to contribute to the family's budget?
  - Is that requirement expected to change?
- Utilize family finding techniques[11] to support the interests of many TAY in re-connecting (especially for young adults aging out of foster care).

11 National Institute for Permanent Family Connectedness family finding website: http://www.senecacenter.org/familyconnectedness

Ethnic Minority and LGBTQ Youth Suicide and Suicide Risk

Purpose

To improve provider awareness of suicide risk in specific ethnic and cultural groups, and to identify tools for working with suicidal youth of diverse backgrounds.

Definition

Suicide is the third-leading cause of death for youth ages 15 to 24. Among *ethnic minority and LGBTQ youth, suicide and suicide risk* are even more prevalent, in the form of suicide ideation, gestures, or suicide itself.

- For American Indian and Alaska Native youth, suicide is the second-leading cause of death, constituting 75% of all mortality. The rate of suicide for American Indian and Alaska Native youth is 2.4 times the national average.[12]

12 U.S. Department of Health and Human Services, Office of Minority Health. (2008*). Suicide and suicide prevention 101.* Retrieved from http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=136

Definition (cont'd)

- Results of the National Youth Behavior Risk Survey suggest that Latina youth report high levels of suicidal behavior. Approximately one in 25 Latina youth report having attempted suicide in the past year, a rate two times that of White and African American youth. In addition, Latina youth are more likely to report having made a suicide plan and having feelings of hopelessness.[13]
- Asian/Pacific Islander women ages 15–24 have the highest rates of suicide among women of that age group.[14]
- Although prevalence data for Hmong youth are not available, several completed youth suicides in this relatively small population indicate that suicide is a significant issue affecting Hmong youth.[15]
- Although national estimates for LGBTQ youth suicidal behavior are not available, scholarly research with LGB participants provides insight into the extent of this problem. Studies indicate that LGB youth are 3 to 4 times more likely to attempt suicide than their heterosexual counterparts. In addition, research suggests that approximately 40% of LGB adults report having attempted suicide at some point during their youth.
- Although research examining suicidal behavior in transgender and questioning youth is sparse, the available research suggests similarly elevated risk for these groups.[16]

13 Centers for Disease Control and Prevention. (2007). National youth risk behavior survey telebriefing. *Press priefing transcripts.* Retrieved from http://www.cdc.gov/media/transcripts/2008/t080604.htm
14 U.S. Department of Health and Human Services, Office of Minority Health. (2008*). Suicide and suicide prevention 101.* Retrieved from http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=136
15 U.S. Department of Health and Human Services, Office of Refugee Resettlement. (2002). *State letter #02-38* [regarding suicide prevention for Hmong adolescents]. Retrieved from http://www.acf.hhs.gov/programs/orr/policy/sl02-38att.htm
16 Suicide Prevention Resource Center. (2008). Suicide risk and prevention for lesbian, gay, bisexual, and transgender youth. Newton, MA: Education Development Center, Inc. Retrieved from http://www.sprc.org/sites/sprc.org/files/library/SPRC_LGBT_Youth.pdf

Implementation Strategies

As in all cases of suicidal behavior, the first priority for providers should be to assess the level of suicide risk and to follow agency protocol to ensure client safety. However, when working with minority youth, providers should consider the following cultural factors:

- Be aware of cultural differences in attitudes toward suicide as well as spiritual beliefs regarding suicide because these beliefs may affect clients' willingness to engage in discussions regarding suicide risk.
- Consult with cultural brokers to identify culturally acceptable ways to assess suicide risk. Providers who are not familiar with cultural norms regarding discussion, prevention, and incidence of suicide may consider employing a cultural broker to assist in developing a safety plan with the client and family.
- Be aware of culture-specific experiences that contribute to suicide risk, including:
  - Racism, discrimination, and homophobia. Minority clients who are the victims of racism may experience heightened stress, depression, anger, isolation, and frustration.
  - Alienation, marginalization, and isolation. Minority clients may feel excluded from civic life and alienated. These feelings may decrease individuals' willingness to seek services and increase their sense of loneliness and depression.
  - Immigration and acculturation. Acculturation stress, separation from family and friends, and difficulty adjusting to life in the U.S. may contribute to feelings of depression and suicidal ideation.
- Educate youth about the potential impact of discrimination on health and mental health, and validate their feelings regarding their victimization.

Implementation Strategies (cont'd)

- Help youth find ways to feel empowered in the face of oppression. Some youth may gain strength and confidence by participating in or taking a leadership role in LGBTQ student advocacy groups.
- Consider that LGBTQ youth may encounter difficulty in developing a healthy sexual identity, including rejection by family members, friends, teachers, church leaders and members, and others. As a result, the quest for a healthy sexual identity may lead to feelings of loneliness, hopelessness, low self-worth, depression, and suicidal behavior.
  - For youth who decide against coming out, the experience of hiding their feelings may cause significant isolation and stress.
  - For those who do choose to come out, hurtful experiences of rejection and harassment may ensue. Be aware of the LGBTQ youth's feelings about coming out, and the ways in which coming out or avoidance of coming out has affected his or her relationship with others, self-esteem, and mental health.
- Assist clients in identifying and connecting with supportive individuals and organizations. Because the social isolation that many ethnic and cultural minority youth experience may cause depression, hopelessness, and suicidal behaviors, assessing social support and strengthening social networks should be an important priority in treatment.
- Recognize that LGBTQ youth of color may experience increased social isolation as a result of rejection by their community because of their sexual orientation and by other LGBTQ youth because of their race or ethnicity. LGBTQ youth of color may have more difficulty than their White counterparts in finding LGBTQ role models within their communities.

Resource Guide

Each of the tools listed below has specific resources that you can locate in the general resource section on pages 48-50. This guide enables you to focus on the pertinent resources linked directly to each tool.

Name of Tool	Resource Number(s)
Creating a Cultural Formulation	8
Understanding Ethnic-Specific Protective Factors and TAY Identity Formation	11, 15, 18
Acculturation	3, 7
Social Determinants of Mental Health (Socioeconomic Status)	1, 2. 9
Understanding Cultural Variations When Making the Transition to Adulthood	*
Using Complementary and Alternative Treatments	6, 12
Developing Knowledge of Populations Served: History and Culture	10, 13, 14
Understanding the Role of Biological, Extended, and Client-Identified Families	19
Ethnic Minority and LGBTQ Youth Suicide and Suicide Risk	4, 5, 16, 17

* Refer to Appendix A: General Resources

Resources

✔ Articles

1. Groh, C. J. (2007). Poverty, mental health, and women: Implications for psychiatric nurses in primary care settings. *Journal of the American Psychiatric Nurses Association, 13*(5), 267–274.

2. Kuruvilla, A., & Jacobs, K. S. (2007). Poverty, social stress, and mental health. *Indian Journal of Medical Research, 126,* 273–278.

3. Miller, K. E. (1999). Rethinking a familiar model: Psychotherapy and the mental health of refugees. *Journal of Contemporary Psychotherapy, 29*(4), 283–290.

4. Suicide Prevention Resource Center. (2008). Suicide risk and prevention for lesbian, gay, bisexual, and transgender youth. Newton, MA: Education Development Center, Inc. Retrieved from http://www.sara.lu/my_special_data/Studies_and_abstracts/Preventing%20Suicide%20among%20Gay,%20Lesbian,%20Bisexual,%20Transgendered,%20and%20Questioning%20Youth%20and%20Young%20Adults.pdf

5. U.S. Department of Health and Human Services, Office of Minority Health. (2008*). Suicide and suicide prevention 101.* Retrieved from http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=136

6. Werneke, U. (2009). Complementary medicines in mental health. *Evidence Based Mental Health, 12,* 1–4.

✔ Assessment

7. Multicultural test titles (acculturation and ethnic identity measures) on the Antioch University Multicultural Center website: http://www.multiculturalcenter.org/test/

✔ Books

8. American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (4th ed., text revision). Washington, DC.

9. Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health.* Geneva, Switzerland: World Health Organization. Retrieved from http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

10. Der-Karabetian, A., Dana, R. H., & Gamst, G. C. (2008). *CBMCS multicultural training program: Participant workbook.* Thousand Oaks, CA: Sage Publications.

11. Martinez, V. (1996). *Parrot in the oven: Mi vida.* New York, NY: HarperCollins Inc.

12. Moodley, R., & West, W. (2005). *Integrating traditional healing practices into counseling and psychotherapy.* Thousand Oaks, CA: Sage Publications, Inc.

13. Morales, P. (1999). The impact of cultural differences in psychotherapy with older clients: Sensitive issues and strategies. In M. Duffy (Ed.), *Handbook of counseling and psychotherapy with older adults.* New York, NY: John Wiley & Sons, Inc.

14. Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation.* Hoboken, NJ: John Wiley & Sons, Inc.

15. Wakatsuki, J., & Houston, J. (1973). *Farewell to Manzanar: A true story of Japanese American experience during and after the World War II internment*. New York, NY: Bantam Books.

✔ Meeting Proceedings

16. Centers for Disease Control and Prevention. (2007). National youth risk behavior survey telebriefing. *Press priefing transcripts.* Retrieved from http://www.cdc.gov/media/transcripts/2008/t080604.htm

✔ Report

17. U.S. Department of Health and Human Services, Office of Refugee Resettlement. (2002). *State letter #02-38* [regarding suicide prevention for Hmong adolescents]. Retrieved from http://www.acf.hhs.gov/programs/orr/policy/sl02-38att.htm

✔ Video

18. Casey Family Programs. (n.d.). *Knowing who you are* [DVD]. Seattle, WA. Retrieved from http://www.casey.org/resources/initiatives/KnowingWhoYouAre/video.htm

✔ Website

19. National Institute for Permanent Family Connectedness family finding search services: http://www.senecacenter.org/familyconnectedness

Domain #2

Cultural Barriers to Care

According to the President's New Freedom Commission report on Mental Health, "in a transformed mental health system, all Americans will share equally in the best available services and outcomes, regardless of race, gender, ethnicity, or geographic location." However, minority communities continue to experience disparities in access to and quality of care. Mental health providers across the state must continue in efforts to engage communities of color. The purpose of this domain is to identify and resolve barriers that impede services for clients from diverse cultural and ethnic backgrounds.

Developing Culturally Responsive, Effective Outreach and Engagement Strategies for Specific Under-represented Ethnic Populations (UREPs)

Purpose

To reduce racial, ethnic, and cultural disparities within TAY FSP programs by employing culturally sensitive outreach, engagement, and intervention strategies.

Definition

Developing culturally responsive, effective outreach and engagement strategies for specific underrepresented ethnic populations (UREPs) is critically important for improving ethnic and racial minority individuals' access to treatment and retention in services. TAY FSPs must develop and implement strategies to identify, contact, and engage unserved, underserved, and inappropriately served groups.

Implementation Strategies

- Obtain demographic data from DMH Cultural Competency Plans, United Way and other local planning authorities that identify the ethnic and racial makeup of the service community, and compare the data with FSP client demographics to identify any disparities.
- Use the Race Matters tool kit[17], or a similar guide, to facilitate advocacy efforts for calling attention to disparities and for promoting racially equitable opportunities and results.
- Establish relationships with ethnic and cultural minority and spiritual leaders, immigration and refugee advocacy agencies, and cultural arts organizations to engage the community in mental health psychoeducation, advocacy, and outreach efforts.
- Utilize strategic planning workshops comprising community leaders, mental health providers, young adults and family members from each of the target populations to advocate for improved, culturally relevant services.
- Collaborate and coordinate with other youth service organizations that are not "branded" as mental health agencies, including gay and lesbian centers, job training sites, and drop-in programs. Expand the scope of activities to respond to other issues (such as housing and employment). By addressing other areas of need, FSP providers may reduce the stigma associated with seeking mental health services.
- Recruit and hire a diverse, bilingual, and bicultural staff that is reflective of the service population.
- Be aware that some individuals may shun services due to fear of disclosing their identities or to lack of trust in government services. LGBTQ clients may face violence and harassment if their sexual identity is discovered.

17 Annie E. Casey Foundation. (2006). *Race matters* tool kit. Retrieved from http://www.aecf.org/SearchResults.aspx?keywords=Race%20Matters&source=topsearch

Implementation Strategies (cont'd)

Individuals from rural communities may fear the stigma associated with seeking services. Take steps to maximize client safety and confidentiality.

- Be aware of local activities of the U.S. Immigration and Customs Enforcement (ICE) agency and the ways in which these activities inhibit Latino service utilization. Clients who are undocumented may be reluctant to seek services for fear of being detected by Immigration and Customs Enforcement.
- Dedicate time in FSP team meetings to explore failed engagements.
- Create opportunities for staff and team members to engage in self-reflection.

Providing Appropriate Language Services

Purpose

To provide guidelines for working with clients who have limited English proficiency.

Definition

Providing appropriate language services entails ensuring that interactions and treatment are conducted whenever possible in the primary language of the client. When providers who speak the client's primary language are not available, language translators should be engaged to ensure effective communication.

Implementation Strategies

- Recruit and hire staff members who speak languages prevalent in the program's service area.
- Develop relationships with graduate schools that train ethnically and linguistically diverse students; develop a training program and career ladder that encourages trained students to remain as staff members.
- Create and translate written forms in a level of language that is accessible for persons with little or no formal education. Consider making photo novellas for certain uses, especially health education.
- Train the staff to pay close attention to the vocabulary they use and to match their diction to the client's educational level. Teach the staff how to assess for level of verbal and written literacy.
- Evaluate the client's literacy level carefully. When working with members of cultures in which written language is limited, be certain to review written material carefully and at a pace that the client finds comfortable and sufficient for good comprehension.

Working with Language Translators

- Develop a network of trained language translators. Ensure that translators are trained in cultural sensitivity, and discourage them from applying their own interpretations of the content.
- Specify, when possible, use of translators who share the client's ethnic background and who have mental health training.
- Maintain eye contact with the client and/or family members.
- Speak clearly, in a regular voice, one to two sentences at a time. Allow extra time for translation and for the family to ask questions.
- Use simple language and avoid jargon.

Implementation Strategies (cont'd)

- Set up the room so that the client and family are facing the provider and the linguistic translator.
- Confer with the translator in advance, if possible, to discuss the content of the session and to develop strategy for communication. Some concepts may not have a direct translation. Work with the translator to develop a phrase or explanation that adequately reflects the constructs being conveyed.
- Check in with the client and family to ensure that they feel comfortable with their understanding of the information.
- Avoid the use of family members or friends as translators, and never use children in that role because of the delicacy and complexity of the subject matter.

Identifying Funding for FSP Clients Without a Payor Source

Purpose

To enable indigent TAY clients who may never qualify for insurance to access FSP services.

Definition

Many unemployed young adults may struggle to qualify for entitlements or may be undocumented immigrants who are ineligible for Medi-Cal. *Identifying funding for FSP clients without a payor source* is critically important for providing services.

Implementation Strategies

- Allocate a large percentage of FSP funds for indigent young adults.
- Dedicate a certain percentage of funding when budgeting for FSP programs that cannot be matched to Medi-Cal and that can be used only for services for clients who lack a payor source.
- Pursue grants to obtain funds to serve clients who are unable to obtain funding for their services.
- Identify, where consents to speak with family exist, any funds that family members can contribute to assist clients in funding services.

Reducing Stigma Associated With Pursuit of Mental Health Service

Purpose

To overcome the fear, mistrust, and sense of shame that discourages many young adults from seeking mental health services.

Definition

Stigma in mental health refers to the negative perceptions that some people may develop about individuals with mental health problems. Stigma manifests differently across cultural groups. Vulnerable young adults can be particularly influenced by the social unacceptability of mental illness and mental health service pursuits. In addition, many TAY are mistrustful due to prior experiences with mental health services that they perceived as coercive and overly focused on medications. The goal of *reducing stigma associated with pursuit of mental health service* requires understanding of the nature and degree of stigma common in the TAY client's family and community, as well as insight about the TAY client's perception of mental illness. With that understanding, providers can engage clients more effectively and help clients and families cope with their own feelings regarding the mental illness, as well as the response of others in their community.

Implementation Strategies

Community Level

- Consider implementing the recommendations contained in the monograph *Creating a Front Porch: Strategies for Improving Access to Mental Health Services*[18] in which a "front porch" is conceptualized as a place where people can be linked to services without being identified as a client.
- Collaborate and coordinate with other youth service organizations that are not "branded" as mental health agencies – such as gay and lesbian centers, job training sites, and drop-in programs – and maintain a low profile by avoiding exclusive focus on mental health issues.
- Consult with cultural brokers and community leaders to gain an understanding of community perspectives on mental illness and culture-specific manifestations of stigma.
- Discourage stigma for specific cultural groups using targeted programming in minority language media – radio, TV, Internet, and through community-based organizations.
- Be aware when addressing stigma that many ethnic and cultural minority groups have a history of oppression by government agencies and mental health organizations. This history may affect clients' and families' willingness to trust these entities.
- Explore the use of the Internet and social networking as a way of putting a friendly, informative face on mental health services, such as NAMI's Strengthofus.com website.

18 Callejas, L. M., Nesman, T., Mowery, D., & Hernandez, M. (2008). *Creating a front porch: Strategies for improving access to mental health services* (Making children's mental health services successful series, FMHI pub. no. 240-3). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research & Training Center for Children's Mental Health. Retrieved from http://rtckids.fmhi.usf.edu/rtcpubs/CulturalCompetence/porch/CultCompPorch.pdf

Implementation Strategies (cont'd)

- Make use of culture-specific resource materials for addressing stigma.
  - National Institute of Mental Health's (NIMH's) "*Real Men. Real Depression*" campaign, which disseminates information and offers resources for Latino men with depression.
  - National Alliance on Mental Illness (NAMI) *Multicultural Action Center,* which provides fact sheets, manuals, and other resources for Latino, African American, Asian/Pacific Islander, Native American/American Indian, and lesbian, gay, bisexual, transgender, queer, and questioning communities.
  - Substance Abuse and Mental Health Services Administration (SAMHSA) *Campaign for Social Inclusion* materials, which contain resources on mental health for African American, Latino, Chinese American, and Native American communities.
- Consider utilizing MHSA – Outreach and Engagement funds to create opportunities for community education and anti-stigma campaigns.
- Explore opportunities through Prevention and Early Intervention and MHSA statewide projects focusing on stigma and discrimination to create additional educational opportunities for communities.
- Create opportunities for shared learning and acceptance among clients, family members, and local communities.

Provider Level

- Establish youth-directed programs to enhance staff as well as client belief in recovery from mental illness.

Implementation Strategies (cont'd)

- Ensure that discussions within team meetings, as well as in general, are characterized by respect for clients and their experiences.
- Eliminate "staff only" restrictions for restrooms and other common areas.

Client Level

- Be aware that stigma manifests differently across cultures. Disclosures regarding mental illness may have a variety of negative consequences for clients, depending on the views of their family, friends, and community. Explore the potential consequences of disclosure when assisting the clients in accessing social support and working with family members.
- Develop an understanding of clients' self-perceptions regarding their illness and the perceptions of their close family members, friends, and community. Explore how these perceptions affect their self-esteem, their willingness to remain in treatment and collaborate with care providers, the degree to which they are able to or willing to access social support, and their recovery process.
- Address stigma in a way that validates the cultural perspectives of clients and families and the desire for confidentiality, while encouraging clients and families to accept and understand mental illness.
- Recognize that in some cultures mental illness may be so stigmatized that families will prefer to remain isolated rather than seek support from family or friends.

Implementation Strategies (cont'd)

- Remember that stigma associated with mental illness may be exacerbated by experiences of discrimination based on race, ethnicity, disability, sexual identity, entry into the foster care system, and other traumatic experiences. Be aware of the interplay of these sources of oppression, and assist clients in identifying and developing strategies for coping with experiences of discrimination.
- Utilize a strengths-based approach to assessment, service planning, and interventions.
- Focus on FSP outcomes when conducting outreach and engaging minority young adults. Make certain that outcome goals are relevant to the youth served – for example, obtaining work, housing, education and relationships, rather than symptom reduction and formal psychiatric treatment.
- Be linguistically and culturally appropriate; avoid mental health jargon, acronyms, and overly complicated language.

Integrating Cultural Explanations for What Causes Mental Illness and What Helps or Heals

Purpose

To form an alliance and rapport with young adults and their families by acknowledging and validating their experiences, and by choosing appropriate words and metaphors.

Definition

Ethnic and cultural minority clients may have views regarding mental illness that are different and/or conflict with the medical model used by many providers. To engage clients of diverse backgrounds in treatment, providers must find ways of *integrating cultural explanations for what causes mental illness, and what helps or heals.* Doing so requires a shared approach to treatment characterized by attentiveness to and incorporation of language, idioms, and descriptions of how the young adult describes his or her internal experiences of illness and disorders.

Implementation Strategies

- Explore the understanding that the client and his or her family members have about the nature, causes, and treatments of the illness.
- Collaborate with the client to find a problem resolution approach that is comfortable and mutually acceptable.
- Engage young adults and their families in discussion that incorporates their explanations and attributions for mental illness, such as described in EPPIC (Early Psychosis Prevention and Intervention Centre) literature.[19]
- Provide information sheets on diagnoses and treatment options in plain, simple phrasing. The American Academy of Child and Adolescent Psychiatry offers information sheets titled "Facts for Families" in various languages, including Spanish, Malaysian, Polish, Icelandic, Arabic, Urdu, and Hebrew.

19 Early Psychosis Prevention and Intervention Centre. (n.d.) *Engagement.* Retrieved from http://www.eppic.org.au/engagement

Resource Guide

Each of the tools listed below has specific resources that you can locate in the general resource section on pages 68–70. This guide enables you to focus on the pertinent resources linked directly to each tool.

Name of Tool	Resource Number(s)
Developing Culturally Responsive, Effective Outreach and Engagement Strategies for Specific Underrepresented Ethnic Populations (UREPs)	11,13
Providing Appropriate Language Services	1,8,9,12,16
Identifying Funding for FSP Clients Without a Payor Source	10,13
Reducing Stigma Associated With Pursuit of Mental Health Service	3,4,6,7,10,13,14,15
Integrating Cultural Explanations for What Causes Mental Illness and What Helps or Heals	2,5

Resources

✔ Articles

1. American Academy of Child and Adolescent Psychiatry. (2010). *Facts for families.* Retrieved from http://www.aacap.org/cs/root/facts_for_families/facts_for_families

2. Anders, J. (n.d.). Don't get disconnected: 10 steps to bridge the language divide. Retrieved September 19, 2011 from http://www.healthleadersmedia.com/HOM-62589-3474/Dont-get-disconnected-10-steps-to-bridge-the-language-divide

3. Callejas, L. M., Nesman, T., Mowery, D., & Hernandez, M. (2008). *Creating a front porch: Strategies for improving access to mental health services.* (Making children's mental health services successful series, FMHI pub. no. 240-3). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research & Training Center for Children's Mental Health. Retrieved from http://rtckids.fmhi.usf.edu/rtcpubs/CulturalCompetence/porch/CultCompPorch.pdf

4. Corrigan, P., & Gleb, B. (2006). Three programs that use mass approaches to challenge the stigma of mental illness. *Psychiatric Services, Vol. 57*(3). 393–398.

5. Early Psychosis Prevention and Intervention Centre. (n.d.) *Engagement.* Retrieved from http://www.eppic.org.au/engagement

6. National Institute of Mental Health (NIMH). (n.d.). *Real Men. Real Depression. Estos hombres son reales. La depresión también* [In Spanish language]. Retrieved from http://www.nimh.nih.gov/health/publications/espanol/real-men-real-depression-estos-hombres-son-reales-la-depresion-tambien/index.shtml

7. Substance Abuse and Mental Health Services Administration (SAMHSA). (2011, October 21). *Campaign for Social Inclusion.* Retrieved from http://www.promoteacceptance.samhsa.gov/CSI/default.aspx

✔ Book

8. Paniagua, F. A. (1998). *Assessing and Treating Culturally Diverse Clients.* Sage Publications: Thousand Oaks, CA.

✔ Report

9. U.S. Department of Health and Human Services, Office of Minority Health. (2011). *National standards for culturally andlLInguistically appropriate services in health care – Final report.* Retrieved December 8, 2011, from http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

✔ Strategic Plan

10. California Department of Mental Health. (2009). *California strategic plan on reducing mental health stigma and discrimination* (excerpt, part 3, pp. 41–52). Retrieved from http://www.dmh.ca.gov/PEIStatewideProjects/docs/Reducing_Disparities/CDMH_MH_Stigma_Plan_09_V5.pdf

✔ Tool Kit

11. Annie E. Casey Foundation. (2006). *Race matters* tool kit. Retrieved from http://www.aecf.org/SearchResults.aspx?keywords=Race%20Matters&source=topsearch

✔ Websites

12. American Psychological Association – Variations for practice for culturally diverse groups: http://www.apa.org/pi/about/publications/caregivers/practice-settings/cultural-issues/index.aspx#

13. California Department of Mental Health, Office of Multicultural Services. California Reducing Disparities Project (CDRP): http://www.dmh.ca.gov/Multicultural_Services/CRDP.asp

14. National Alliance on Mental Illness (NAMI) – Strength of Us online community: http://strengthofus.org/

15. National Alliance on Mental Illness (NAMI) – Multicultural Action Center: http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Resources/MAC_Resources.html

16. National Center for Cultural Competence – Working with linguistically diverse populations: http://www11.georgetown.edu/research/gucchd/nccc/features/language.html

Domain #3

Cultural Self-Awareness

To deliver adequate care in a cross-cultural context, providers must develop an awareness of their own worldviews, culture, beliefs, values, and biases. In addition, providers should consider the ways in which their cultural values and worldviews differ from those of their clients, the ways in which they are similar, and the ways similarities and differences affect the therapeutic relationship. In this domain, important areas for self-awareness are identified with tools and strategies for fostering self-awareness in providers and in FSP team members.

Developing Cultural Self-Awareness or Cultural Humility

Purpose

To help providers understand and address personal biases or ethnic and/or cultural barriers that arise within themselves and that may have an impact on therapeutic effectiveness.

Definition

Developing cultural self-awareness or cultural humility is part of becoming a culturally competent provider. Awareness of one's own cultural values and beliefs and recognition of personal biases and prejudices can help providers to work more effectively with a range of different cultural perspectives and to forge stronger therapeutic alliances with clients.

Implementation Strategies

- Promote self-awareness in FSP team members through periodic exercises that examine personal cultural identity, cultural assumptions, beliefs, biases, attitudes, and values. Hays[20] has developed a framework for self-awareness that includes examining one's identity through recognition of differences across age or generation, disability, spirituality, ethnicity, national origin, indigenous heritage, socioeconomic status, sexual orientation, and gender. (Refer to "Resources" for commonly used self-awareness exercises — e.g., the CBMCS participant handbook by Der-Karabetian et al.)
- Develop an understanding of *White privilege* — the unearned advantages that non-Latino Whites enjoy by virtue of the color of their skin. Discuss the ways in which white privilege manifests itself in power dynamics among FSP team members and clients. Consider asking team members to read material such as Peggy McIntosh's seminal work, *White Privilege: Unpacking the Invisible Knapsack,*[21] and discuss it in the context of FSP service provision.
- Promote awareness of oppression, discrimination, and racism. Develop understanding of the ways in which these social conditions affect clients: their day-to-day experiences, the barriers they face in accessing care, and inequities in access to resources.
- Explore the ways in which the personal worldviews of staff members interact with those of clients and the ways in which differences in worldview affect the clinical encounter, the therapeutic relationship, diagnosis, goal-setting, treatment, treatment implementation, and adherence.
- Develop skills of "dynamic sizing" and "scientific-mindedness."[22]

20 Hays, P. (2001). *Addressing cultural complexities in practice: A framework for clinicians and counselors.* Washington, DC: APA Books.
21 McIntosh, P. (1988). *White privilege: Unpacking the invisible knapsack.* Retrieved from http://www.nymbp.org/reference/WhitePrivilege.pdf
22 Sue, S. (2006). Cultural competency: From philosophy to research and practice. *Journal of Community Psychology, 34*(2), 237–245.

Implementation Strategies (cont'd)

- Dynamic sizing allows application of a person's knowledge of cultural norms within a community in a flexible way — avoiding the pitfall of stereotyping. It involves integrating knowledge about the client's culture with an awareness of the diversity within this culture. Thus, awareness of cultural differences must be combined with an understanding that not all clients of a particular cultural background will share the values, beliefs, and behaviors common in that culture.
- Scientific-mindedness involves approaching cultural information with curiosity, generating hypotheses, and then testing these hypotheses by questioning clients and/or families and cultural brokers. For example, a practitioner may hypothesize that a Latino client is more likely to want to stay home with extended family than to move out of the home, because that is a common value in Latino culture. Scientific mindedness suggests that the practitioner should test this hypothesis by exploring this idea with the client.

- Use cultural competence tools to allow staff members to examine their own level of cultural knowledge, awareness, and skills, and to facilitate discussions about cultural competence. Two frequently used measures are the Multicultural Counseling Inventory and the California Brief Multicultural Competence Scale (CBMCS), along with the Multicultural Awareness-Knowledge-Skills-Survey (MAKSS). Antioch University's Multicultural Center also provides a list of multicultural measures. (Refer to "Resources" section for websites and other retrieval information.)
- Incorporate regular discussion of team and individual staff members' cultural competency strengths and weaknesses into team meetings to promote open and honest analysis of areas of improvement.
- Consider that clients and providers may differ in the way they conceptualize time and the extent to which they are future-oriented vs. present-focused. For clients with predominant orientations to the present, focus on short-term goals that progressively take on a longer-term focus.

Employee Welcoming

Purpose

To welcome and understand the FSP staff's racial, ethnic, and cultural identities, recognizing that unless staff members feel welcomed they will struggle to welcome clients.

Definition

Acknowledging TAY FSP staff's own cultural identities and life experiences can be an important step in strengthening organizational cultural competence and enhancing the welcoming of a diverse TAY population. *Employee welcoming*[23] entails developing some systematic ways or rituals that encourage staff members to introduce themselves and describe their backgrounds and relevant experiences, in the context of creating understanding about how those aspects of their lives can enrich their work environment and their relationships with other staff members as well as clients.

23 Community Activators. (n.d.). *Our door is open: Creating welcoming cultures in helping organizations* [CD]. Vashon, WA. Available from http://www.communityactivators.com/home/our-door

Implementation Strategies

- Encourage staff to include regular opportunities to share stories about their own cultural backgrounds and experiences.
- Consider developing rituals that welcome new staff members by inviting them to talk about "once when they were TAY" and rituals that acknowledge when a staff member leaves.
- Discover the other roles of staff members in their respective communities, their networks, and their voluntary civic activities. They often are willing to share their knowledge of ethnic groups and are passionate about being "cultural ambassadors."
- Post pictures showing staff members in other roles in their communities, in order to allow TAY clients to learn more about resources and allow them to seek out more information if interested. For example, staff members who participate in community events (such as fairs or cultural celebrations) or are members of particular groups (such as LGBTQ groups) may be willing to share this information and thus provide a non-threatening way to connect youth with these resources.
- Be sure to include the entire FSP staff, including receptionists, security guards, clerks, and maintenance personnel, in these information-sharing functions because the entire team plays an important part in creating welcoming, culturally competent environments and relationships.

Welcoming Environments

Purpose

To consider how the physical location, appearance, and building interior can influence young adults' feelings of belonging, and to make constructive modifications whenever possible.

Definition

The process of creating more youth-friendly, *welcoming environments* for young adults can be difficult for many TAY FSPs. Co-location with other adult programs that serve older people with severe mental illnesses. or with children's programs, can be uninviting for many TAY clients. Signage that identifies the program as a mental health agency, intimidating security guards, and long waits in drab waiting rooms are barriers for many young adults seeking services.

Implementation Strategies

- Consider co-locating or relocating TAY FSPs with other youth-friendly, non-branded environments, such as work-force development agencies, community colleges, storefronts, and churches whenever possible.
- Create signage that indicates “youth services” or “youth development program,” or other welcoming, non-clinical-sounding names, rather than “mental health services,” whenever possible.
- Strive to designate one room, one wall, or even one bulletin board for TAY when co-located with other mental health programs. Use removable banners that can be decorated with graffiti and other client art works and photographs. Hang posters of well-known ethnic artists, cultural icons, and sports figures.
- Meet youths in pleasant, casual spots, such as parks, coffee houses, Internet cafés, and drop-in centers, if the FSP co-located with other mental health programs. Schedule regular times that TAY FSP staff will be at selected locations away from the FSP office.
- Dedicate the use of at least one computer for TAY clients.
- Find some open space for regular community meetings where TAY clients can meet each other and all FSP staff members. That’s especially advantageous if FSP staff members are assigned to individual offices and cubicles. Rituals such as welcoming, goal setting, and/or activity planning can be considered as possible formats for community meetings.

Community Engagement

Purpose

To map out community resources, form relationships, and find places of belonging for young adults.

Definition

Community engagement describes efforts of TAY FSP staff and clients to discover and participate with other community resources, establish formal and informal linkages, and identify natural supports. Examples include landlords, sober living program operators, job training agencies, employers, community colleges and vocational certification teachers, and ethnic arts and advocacy organizations.

Implementation Strategies

- Perform strategic community mapping activities driven by TAY client needs, talents, and interests. Consider setting goals for FSP team members, such as identifying and meeting with at least five community churches, mosques, clan leaders, tribal leaders, or elders.
- Develop relationships with local police, gang workers, and youth leadership development resources.
- Ask staff members to participate with clients in community activities such as block parties, graffiti removal, and neighborhood clean-ups, thereby helping to establish the TAY FSP as a community asset.
- Organize graduation celebrations and rituals recognizing the achievements and progress of TAY clients. Invite community leaders, family members, agency directors, and other respected figures to see positive contributions.
- Invite ethnic leaders, culture brokers, and ambassadors to use FSP facilities if they lack space for board meetings and other functions. Connect with other youth-oriented places of belonging – such as gay-lesbian centers, Internet cafés, youth opportunity centers, one stops, and coffeehouses – and ask permission to keep FSP brochures, flyers, and announcements posted there.

Experiences of Racism, Discrimination, and Homophobia

Purpose

To increase FSP team awareness of the impact of racism, discrimination, and homophobia on the client's worldview, and to understand and address provider biases that may hinder the treatment relationship and treatment effectiveness.

Definition

Experiences of racism, discrimination, and homophobia may affect clients – directly, through overt acts of violence and discrimination, or indirectly, by limiting access to resources and opportunities. In addition, racism and homophobia can take the form of microaggressions: "…brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color."[24] Experiences of discrimination based on race, ethnicity, or sexual identity can cause profound and lasting suffering, isolation, stress, and feelings of hopelessness and despair.

24 Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri J. M., Holder, A. M. B, Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62,* (271–286).

Implementation Strategies

- Provide education for staff and providers regarding racism, discrimination, and homophobia. In particular, staff and providers should be aware of the history of discrimination in social service systems and in the criminal justice system. Research indicates that increasing awareness of discrimination may reduce biased decision-making.
- Advocate for changes in systems when discriminatory practices occur.
- Assess the role that oppression based on race, ethnicity, or sexual identity plays in a client's clinical presentation and worldview, including how such oppression affects trust, belief in recovery, and interest in regaining integration into a community. When appropriate, discuss clients' experiences of racism, homophobia, and microaggressions, and the ways in which these experiences affect them.
- Discuss the client's thoughts and feelings about having a therapist or provider of a different race, ethnicity, or sexual identity.
- Establish a relationship that is egalitarian, to the degree possible. Self-disclosure, for instance, can often promote a greater sense of equality and trust. While counselor self-disclosure often is discouraged in traditional psychotherapy, judicious use of self-disclosure can help to foster a greater sense of trust in minority clients.
- Acknowledge cultural differences between the client and provider including, where applicable, the limitation in understanding resulting from lack of lived experience with mental illness.
- Explore the ways in which the client has responded to racism or homophobia in the past, and discuss the effectiveness of these strategies. Assist the client in identifying effective strategies for coping with and responding to discrimination.
- Be prepared to advocate with or on behalf of your client when he or she experiences racism or homophobia.

Resource Guide

Each of the tools listed below has specific resources that you can locate in the general resource section on pages 84–85. This guide enables you to focus on the pertinent resources linked directly to each tool.

Name of Tool	Resource Number(s)
Developing Cultural Self-Awareness or Cultural Humility	2,3,4,5,6,7,12,13
Employee Welcoming	11
Welcoming Environments	8
Community Engagement	1
Experiences of Racism, Discrimination, and Homophobia	9,10

Resources

✔ Articles

1. Sue, D. W. , Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, 62(4), 271–286.

2. Sue, S. (2006). Cultural competency: From philosophy to research and practice. *Journal of Community Psychology, 34*(2), 237–245.

✔ Assessments

3. Antioch University Multicultural Center: Access to multicultural measures (list of multicultural measures). [Page includes link to Multicultural Counseling Inventory.] Retrieved from http://www.multiculturalcenter.org/access.cfm

4. CBMCS (California Brief Multicultural Competency Scale) Multicultural Training Program: http://www.sagepub.com/cbmcs/

5. D'Andrea, M., Daniels, J., & Heck, (1991). Evaluating the impact of multicultural counseling training. *Journal of Counseling and Development, 70,* 143–170.

6. Sodowksy, G. R., Taffe, R. C., Gutkin, T. B., & Wise, S. L., (1994). Development of the Multicultural Counseling Inventory: A self-report measure of multicultural competencies. *Journal of Counseling Psychology, 41,* 137–148.

✔ Books

7. Hays, P. (2001). *Addressing cultural complexities in practice: A framework for clinicians and counselors.* Washington, DC: APA Books.
8. Ponterotto, J. G., Casas, J. M., Suzuki, L. A., & Alexander, C. M. (2010). *Handbook of multicultural counseling* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.
9. Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.) New York: John Wiley and Sons.

✔ Brief

10. Wong, B. (2008). *Using culture to build community: How Oakland arts activists turned their dream into the reality of the EastSide Cultural Center – A case study.* The Annie E. Casey Foundation. Retrieved from http://www.aecf.org/KnowledgeCenter/Publications.aspx?pubguid={178CDFFC-4BB5-4AB7-AB9B-AADD36945110}

✔ CD

11. Community Activators. (2010). *Our door is open: Creating welcoming cultures in helping organizations.* Retrieved from http://www.communityactivators.com/home/our-door

✔ Essay

12. McIntosh, P. (1988). White privilege: Unpacking the invisible knapsack (Essay excerpted from working paper *White privilege and male privilege: A personal account of coming to see correspondences through work in women's studies*). Retrieved September 19, 2011, from http://www.nymbp.org/reference/WhitePrivilege.pdf

✔ Training Workbook

13. Der-Karabetian, A., Dana, R. H., & Gamst, G. C. (2008). *CBMCS Multicultural Training Program: Participant Workbook.* Thousand Oaks, CA: Sage.

Domain #4

Sociocultural Diversities

Members of racial, ethnic and other sociocultural minority groups may be subject to social and economic adversity, bias, discrimination, and inequities in access to and quality of mental health care. Further, some communities experience multiple forms of minority status. For example, ethnic minority individuals who identify as lesbian, gay, bisexual, transgender, queer, or questioning often experience various forms of oppression. The Sociocultural Diversities domain focuses on general strategies for engaging and working with numerous groups, and on the intersection of multiple forms of minority status.

Understanding Developmental Appropriateness in TAY as its Own Diverse Culture

Purpose

To address the many challenges that TAY FSP programs face in delivering developmentally appropriate services to "emerging" adults. In addition, to understand the youth culture and its influences on communications, relationships, language, and values.

Definition

Understanding developmental appropriateness in TAY as its own diverse culture means taking into account maturational differences and delays in young adults, and recognizing that while they are legally adults, many have not yet achieved adult milestones and skill sets. Keep in mind that the average young adult requires prolonged financial and emotional supports from families to establish self-sufficiency; age 30 is the average age of emancipation in America, according to 2000 census data. That suggests the difficulties in establishing incomes, housing, jobs, and relationships in our increasingly complex society.

Implementation Strategies

- Schedule drop-in hours whenever possible to accommodate poorly developed time management skills and less parental or adult support.
- Develop more refined outcome measures that capture incremental steps toward long-term goals (e.g., counting the number of interviews rather than employment, or taking on-line courses rather than school enrollment).
- Emphasize “in-vivo” contacts with real-world environments to provide exposures. Many young adults may lack sufficient life experience to have clear goals of what they would like to do for employment or education, and involvement in relationships.
- Remember that self-care skills and self-awareness may not be highly developed in some TAY clients. This shortcoming may be seen as an impediment to interventions that require self-monitoring, such as WRAP (wellness recovery action plans) and illness management and recovery. Start with basic skills of emotion identification and self-soothing.
- Consider that many TAY clients may be quite dependent and lack self-direction. Make certain you don’t confuse chronological age with developmental age, and instead meet clients at their developmental and comfort level.

Working With Young Adults From Foster Care Backgrounds

Purpose

To understand the disruptive and traumatic long-term impacts of childhood abuse and/or abandonment, and the resulting effects of out-of-home placements. on young adults' development, relationships, and overall functioning.

Definition

Effectiveness in *working with young adults from foster care backgrounds* who have mental health problems as they age out of the foster care system requires specific knowledge and sensitivity. FSP personnel must understand the daunting obstacles that TAY are likely to encounter as they progress toward achieving the adult milestones to sustain independent living, including employment, adequate housing, and education, as well as attaining basic emotional and physical well-being. Minorities who are substantially overrepresented in foster care are more likely to face impediments.

Implementation Strategies

- Assess need for frequency and duration of contacts, as well as additional housing and life coaching supports. Young adults aging out of foster care frequently require more structure and regularity than young adults living with parents or caregivers.
- Consider that many young people coming from foster backgrounds struggle to meet basic survival and safety needs. Partner with emergency housing resources, food banks, general relief, and drop-in programs that can play essential roles in helping to stabilize them in the community.
- Make a strong commitment to "hang tough" and persevere with young adults from foster care backgrounds. Doing so is important because they typically need services longer than TAY clients with involved families.
- Consider conducting trauma-informed care with an emphasis on achieving safety. Preparation of educational materials and establishment of informational groups can be important early steps in the transition toward independent well-being.
- Disruptive behaviors and frequent substance abuse necessitate having robust relationships with agencies and individuals who offer multiple housing options, including "wet" housing (tolerant of drug and alcohol use).
- Instill in foster youth the importance of keeping track of their documents as they undergo their many transitions. Assist clients in ensuring that birth certificates, health insurance cards, social security cards, and other important documents are kept in a safe and accessible place. For some clients, an online health portal may be helpful.
- Help TAY foster youth develop a sense of self by providing a space to explore values, beliefs, and traditions that are important to them. For many ethnic and cultural minority foster youth, establishing a sense of cultural

Implementation Strategies (cont'd)

identity, ethnic pride, or sexual identity may be particularly difficult given frequent placement changes and potential lack of access to culturally similar role models. Acknowledge that the processes of building a sense of self and connecting with culture and community can be demanding due to diverse and often culturally incongruent foster placements.

- Assist TAY clients in connecting with agencies, organizations, groups, or individuals (e.g., Big Brothers or Big Sisters) who can help reinforce the youth's connection to their culture of origin.

Working Effectively with Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Young Adults

Purpose

To establish safety and trust with LGBTQ youth and young adults in need of FSP services.

Definition

Working effectively with lesbian, gay, bisexual, transgender, and questioning (LGBTQ) young adults begins with understanding that they constitute a sociocultural group that has been subjected to great discrimination, stigma, and harassment. Many LGBTQ young adults may be struggling to attain self-acceptance as well as the acceptance and support of parents and peers. In contrast to Caucasians, LGBTQ youth of color face unique demands, including integrating both racial and sexual identities; facing racism from within the LGBTQ community; and devaluation and rejection from their families. LGBTQ youth of color also may mistrust mental health and government agencies due to prior unpleasant or unproductive interactions with mental health professionals.

Implementation Strategies

- Consult with LGBTQ experts in the community regarding resources available and safety concerns for LGBTQ youth if unfamiliar with LGBTQ issues.
- Recognize that LGBTQ youth face significant challenges in developing a positive sexual identity. Some youth may want to "come out" to parents, peers, or other community members, while others may prefer to keep their sexual identity to themselves. Help youth explore options regarding coming out, discussing the potential repercussions of decisions to come out, or to refrain from coming out. Respect clients' decision, keeping their sexual identity confidential.
- Ascertain the emotions that may ensue in both the youth and family members for youth who do come out. Assist youth and family in coping with these emotions.
- Remember that LGBTQ youth who come out may experience discrimination and harassment by peers, teachers, family, and other community members. Be prepared to actively advocate for youths' rights and to denounce teachers or other community leaders who alienate youth because of their sexual identity – when doing so is appropriate and beneficial to the client, and with the consent of the client.
- Consider that in some communities, homophobic attitudes may be pervasive and intense. In these communities be sure to take precautions to ensure the safety of LGBTQ youth, such as ensuring anonymity in services, avoiding identifying groups or individuals as LGBTQ, and developing safety plans for youth.
- Identify the TAY FSP agency as a "safe zone" by affixing a pink triangle or rainbow decal on windows or bulletin boards to signify that the provider is welcoming and open-minded.

Implementation Strategies (cont'd)

- Familiarize the FSP staff with the lexicon of the LGBTQ community by distributing a glossary of suggested terms (such as the one available from (www.safeschoolscoalition.org).
- Access available resources and guidelines for helping families support their LGBTQ child.
- Engage with community-based LGBTQ resources and agencies, and discuss ways to collaborate. FSP staff members should visit LGBTQ centers to meet with TAY clients who regard that setting as safer and more comfortable than other locales.
- Make LBGTQ literature, pamphlets, and informational websites available to TAY clients.

Exploring Spirituality and Worldviews

Purpose

To discover the role that spirituality may play in the lives of TAY FSP clients and their families.

Definition

Exploring spirituality and worldviews can be important as components of many TAY clients' resiliency, sense of hope and purpose, coping style, and connection to a larger community. Alternatively, spirituality and worldviews also can be sources of shame, blame, and misinformation. Ethnic-specific protective factors (described in the "Multicultural Knowledge" domain), strengths, and community supports can make powerful contributions to TAY clients' recovery and well-being. Spirituality is not an important value or interest of all TAY clients, and providers should be sensitive in exploring this subject.

Implementation Strategies

- Ask TAY clients who have indicated that spirituality is important to them if they are involved with any faith-based community. If they are not, lend help if they express interest in finding churches, synagogues, temples, and mosques in their community, and offer to coach them in meeting people and initiating conversations.
- Consider ethical approaches for taking spiritual assessments.[25]
- Train staff in taking spiritual histories, using any of six models.[26]
- Include spiritual assessments with trauma-exposed TAY clients, because spirituality and sustaining beliefs can be important parts of their recovery.
- Consider recommending yoga, prayer, or other meditative practices for TAY clients with spiritual interests. Meditation and other forms of religious introspection can serve as key self-soothing; emotional regulation skills that may help clients cope with stress, adverse events, and symptoms.
- Introduce NAMI's Sharing Hope: Understanding Mental Health,[27] which targets African American congregations of all denominations to educate clergy and churchgoers about mental illness and recovery.

25 Blum, P., and Lukoff, D. (2009, October 1). *Taking a spiritual history – Six models.* (From: Ethical considerations with spiritual assessments.) Conference presentation, retrieved from http://mhspirit.org/uploads/2009-10-01MH-SpiritWebcastHandoutonSpiritualAssessments.pdf

26 Blum, P., and Lukoff, D. (2009, October 1). *Taking a spiritual history – Six models.* (From: Ethical considerations with spiritual assessments.) Conference presentation, retrieved from http://mhspirit.org/uploads/2009-10-01MH-SpiritWebcastHandoutonSpiritualAssessments.pdf

27 NAMI Sharing Hope materials, from NAMI Multicultural Action Center. Retrieved from http://www.nami.org/Template.cfm?Section=Multicultural_Support1&Template=/ContentManagement/ContentDisplay.cfm&ContentID=55933

Working with Immigrant and/or Refugee Young Adults

Purpose

To promote understanding and knowledge of relevant historical events and cohort membership, including immigration trauma, that affect the ability of the youth and family to participate in and respond favorably to treatment. To assist in understanding the distinction between stressors that are common to immigrant and refugee experiences and stressors that can precipitate trauma.

Definition

The impact of immigration on youth and families is specific to the process of migration or to the ensuing impediments when *working with immigrant and/or refugee young adults.* Traumatic events may occur (1) prior to immigration (events that were experienced before leaving the home country and contributed to the decision to relocate); (2) while immigrating to a new country (physical and psychological events such as injury, fear, torture, or exploitation); (3) after immigrating and while seeking stability, and encountering substandard living conditions, such as unemployment, poverty, lack of supports and minority discrimination or persecution.

Implementation Strategies

- Assess for immigration trauma or challenges.
  - What was the youth's situation before immigrating? Did he or she experience poverty, hunger, exposure to violence or war? Was the youth placed in a refugee camp?
  - Did the youth experience deprivation or exploitation during the immigration journey?
  - After immigrating, how has the youth coped with resettlement?
- Be aware that many refugees experience significant emotional upheaval related to exposure to war. Post-traumatic stress symptoms or post-traumatic stress disorder, depression, suicidal ideation, and anxiety are common among refugees. While many youth may not have direct exposure to war, their parents may have significant psychopathology due to their war-related experiences. Assist youth in understanding and coping with their parents' suffering.
- Provide psychoeducation for youth on effects of exposure to war so that they may understand their parents' emotions.
- Facilitate family conversations regarding war-related experiences.
- Explore treatment options with parents for their own mental health problems.
- Children of immigrants and refugees may have increased responsibilities because they often have greater English proficiency than their parents and thereby acquire skills for navigating institutions more readily. Acknowledge the pressure and burden that those responsibilities place on youth, and identify strategies for coping with additional pressures.

Implementation Strategies (cont'd)

- Children of immigrants and refugees also may be a primary source of emotional support for parents who have left family and community support behind in countries of origin. Help families recognize the stress of isolation, and support youth in finding ways that are culturally congruent for coping with emotional demands. Assist families in finding community sources of support.
- Form partnerships with immigration rights organizations to advocate for needed care and financial assistance.
- Seek sponsoring families who are already documented residents and/or U.S. citizens.
- Understand the county's policy on serving undocumented clients.
- Develop funding streams that are not dependent on insurance benefits.
- Be aware of stress related to lack of documentation. Undocumented status may affect youths' willingness or ability to obtain mental health services and their access to food, shelter, education and other resources. In addition, fear of deportation may limit their activities and may be a source of significant anxiety. Acknowledge these stressors, and help youth cope with anxiety and stress.

Working With Young Adults Who Are Pregnant or Parenting

Purpose

To accommodate and support TAY FSP clients who are pregnant or who are parents.

Definition

Parenting and pregnant TAY clients encounter particular obstacles to accessing FSP services. Providers often lack space that is adequate and appropriate for *working with young adults who are pregnant or parenting.* Inability of providers to accommodate supervision of the children of TAY clients can impede effective engagement and treatment. Pregnant TAY females may become overwhelmed with additional health-care, nutritional, and financial demands. In addition, psychiatrists may be limited in their abilities to prescribe psychotropic medications for the safety of the mother and baby.

Implementation Strategies

- Recognize that attitudes toward teen parents may differ significantly across cultures, within cultures, and within communities and families. Assess the youth's own perceptions of her pregnancy, as well as those of her partner, their peers and family members.
- Assist youth who experience isolation in accessing support and who need help in coping with rejection by peers or family. Connect them with youth parenting groups or other support services.
- Access resources on "Mamas y Bebes,"[28] which is available in English and Spanish on the Internet and presents and explains helpful interventions for young Latino mothers.
- Provide supportive in-home services and outreach to lessen the strain of traveling to appointments and arranging day care.
- Involve the extended family in support plans through which parenting and pregnant TAY clients may obtain baby-sitting, transportation, and emotional help.
- Assign two staff members to support each pregnant or parenting TAY client. With such a team approach, one staff member can attend to young children and model parenting skills, while the other concentrates on the client's mental health needs.

28 UCSF School of Medicine – Latino Mental Health Research Program. (n.d.). *The mothers and babies course: A reality management approach.* Retrieved from http://www.medschool.ucsf.edu/latino/manuals.aspx - motherandbabies

Resource Guide

Each of the tools listed below has specific resources that you can locate in the general resource section on page 103. This guide enables you to focus on the pertinent resources linked directly to each tool.

Name of Tool	Resource Number(s)
Understanding Developmental Appropriateness in TAY as its Own Diverse Culture	*
Working With Young Adults From Foster Care Backgrounds	*
Working Effectively With Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Young Adults	*
Exploring Spirituality and Worldviews	1,2,4,5
Working With Immigrant and/or Refugee Young Adults	*
Working With Young Adults Who Are Pregnant or Parenting	3

* Refer to Appendix A: General Resources

Resources

✔ Article

1. Ryan, C. (2009). *Helping families support their lesbian, gay, bisexual and transgender (LGBT) children* [practice brief]. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development. Retrieved from http://www11.georgetown.edu/research/gucchd/nccc/documents/LGBT_Brief.pdf

✔ Assessments

2. Blum, P., & Lukoff, D. (2009). *Ethical considerations with spiritual assessments* [workshop presentation handout]. Retrieved from http://mhspirit.org/uploads/2009-10-01MHSpiritWebcastHandoutonSpiritualAssessments.pdf

✔ Manual

3. UCSF School of Medicine – Latino Mental Health Research Program. (n.d.). *The mothers and babies course: A reality management approach.* Retrieved from http://www.medschool.ucsf.edu/latino/manuals.aspx - motherandbabies

✔ Websites

4. Safe Schools Coalition – An International Public-Private Partnership in Support of Gay, Lesbian, Bisexual and Transgender Youth: www.safeschoolscoalition.org

5. NAMI Multicultural Action Center – Sharing Hope: http://www.nami.org/Template.cfm?Section=Multicultural_Support1&Template=/ContentManagement/ContentDisplay.cfm&ContentID=55933

Domain #5

Specific Practices

The Specific Practices domain includes several tools intended to assist counties in exploring effective treatment options for ethnic and cultural minorities. The domain explores and analyzes four types of interventions: evidence-based practices (EBPs), culturally adapted EBPs, community-defined practices (CDPs), and culture-specific treatments. The first tool, "Overview of Specific Practices," presents a rationale for the review of practices as well as a brief description of each category of practice.

Overview of Specific Practices

Purpose

To help counties explore options for conducting culturally relevant interventions for diverse communities.

Definition

Decades of research have documented disparities in mental health care for ethnic and cultural minorities. Ethnic minorities tend to be less likely than the general population to receive mental health treatment and less likely to receive high-quality mental health care.[29] The causes of these disparities are multifaceted, and efforts to improve access to and quality of care for ethnic minorities have taken several approaches. One approach has been to identify the specific treatment options that are effective with minority communities.

29 U. S. Surgeon General. (2001). *Mental health: Culture, race, and ethnicity. A supplement to mental health: A report of the surgeon general.* Office of the Surgeon General, Center for Mental Health Services, National Institute of Mental Health. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from http://www.surgeongeneral.gov/library/mentalhealth/cre/sma-01-3613.pdf

Definition (cont'd)

Several tools have been developed to assist counties in exploring effective treatment options for ethnic and cultural minorities. This domain reviews four types of interventions: evidence-based practices (EBPs), culturally adapted EBPs, community-defined practices (CDPs), and culture-specific treatments. The domain presents these practices discretely, with recognition that overlap exists among categories. These categories are continually evolving as research enhances understanding of the meaning of these categories and identifies further treatments within each category. Here is an *overview of specific practices*:

Evidence-based practices: Some EBPs have been tested and yielded positive outcomes with ethnic and cultural minority groups. These are listed in the specific age-group EBP tools in this domain, and are identified based on information from the National Registry of Evidence-based Programs and Practices (NREPP). In addition, while many EBPs have not been tested with ethnic minority clients, theoretical literature suggests that an EBP may be appropriate in some cases for a community, despite lack of evidence supporting its use with that particular group. For example, if the culture in the community emphasizes family relationships, interpersonal warmth, and interdependence, an EBP that reflects those values may be effective. In the absence of other effective interventions, implementation of this EBP may be appropriate.

Culturally adapted evidence-based practices: Studies have suggested that EBPs may be effective with a specific community in some cases when implemented with adaptations. For example, an EBP might work best with a particular community when it includes discussion of acculturation issues or an emphasis on interpersonal warmth or "personalismo." Cultural adaptations vary across EBPs and across communities; however, given the emphasis on empirical study that is central to EBPs, adaptations generally are adopted only after research suggests that they improve the efficacy of the practice.

Definition (cont'd)

Community-defined practices: A "set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community"[30] are known as community-defined practices. In 2009, the California Department of Mental Health initiated the California Reducing Disparities Project – which funded five strategic planning groups representing African Americans, Latinos, Asian/Pacific Islanders, lesbian, gay, bisexual, transgender, and questioning people, and Native Americans – to explore community-based practices.

Culture-specific programs: In a few instances, interventions have been created for a specific cultural group, and have been tested using empirical methods.

30 Martínez, K. (2008, Fall/Winter). Culturally defined evidence: What is it? And what can it do for Latinas/os? El Boletin (Newsletter of the National Latina/o Psychological Association).

The National Registry Of Evidence-based Programs And Practices (NREPP)

Purpose

To provide an orientation to the National Registry of Evidence-based Programs and Practices (NREPP) that will assist providers in using this tool to identify programs and practices that have proven efficacy with specific populations.

Definition

Mental health scholars and progressive social services agencies have placed increasing national emphasis during recent years on implementation of evidence-based interventions that have demonstrably improved outcomes for clients in mental health. To facilitate broad-scale implementation of these practices, mental health researchers are intent on identifying, investigating, and compiling lists of treatments that work. One of those research initiatives is the *National Registry of Evidence-based Programs and Practices (NREPP),* the focus of this tool. The "Resources"

Definition (cont'd)

section at the conclusion of this domain identifies sources for examples of other approaches.

The NREPP is a "searchable online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers."[31] As of early April 2012, the registry contained 230 interventions, more than half of which are prevention programs.

The NREPP includes interventions that have undergone a review process. To qualify for the review process, interventions must have been scrutinized in at least one published experimental or quasi-experimental design study that documents evidence that the intervention results in beneficial behavioral outcomes. Once selected for review, interventions are evaluated for:

1. the quality of evidence supporting the efficacy of the intervention, and
2. the readiness for dissemination.

Based on a review of materials, independent raters score the interventions and make recommendations regarding inclusion of the interventions in the registry.

The NREPP is intended to be used as a "decision support tool." That is, users should not assume that interventions listed have sufficient evidence to be appropriate for their communities. Instead, users should carefully examine the information presented to determine whether the interventions listed meet the user's or agency's standards for evidence, whether the intervention is appropriate for the cultural community and for the agency, and whether the intervention responds to the needs of the community.

31 (SAMHSA, 2011).

Implementation Strategies

Use the NREPP database as a first step in identifying potential interventions to be implemented.

> To access the NREPP database, go to http://www.nrepp.samhsa.gov/ and click on "Find an Intervention."

Consider using advanced search for interventions by different categories, including:

- Areas of interest.
- Specific ethnic groups.
- Age groups.
- Outcomes categories.
- Geographic location.
- Setting.

For example, a user might be interested in identifying mental health treatments for Native American young adults to address social functioning in urban locations, and in inpatient settings.

> To perform an advanced search in the NREPP database (at http://www.nrepp.samhsa.gov/) click on "Advanced Search," then select various interventions.

- Learn how to select and implement interventions through the NREPP online course. This course is designed to help walk users through five basic steps of application of evidence-based approaches:
  - Exploration.

Implementation Strategies (cont'd)

- Installation.
- Initial implementation.
- Full implementation.
- Program sustainability.

The course also is intended to guide users in selecting treatments, determining agency needs and resources, and matching interventions with agency needs and resources.

On the NREPP website (http://www.nrepp.samhsa.gov/) select "Learning Center."

Evidence-Based Practices for Transition-Age Youth

Purpose

To assist programs in identifying interventions that have been validated by evidence demonstrating their effectiveness with specific ethnic or racial groups. Drawing upon principles of the National Registry of Evidence-based Programs and Practices (NREPP), this tool identifies interventions for which at least one experimental study supports their use with specific populations. Each county or organization should evaluate the array of data presented for each intervention to determine whether the empirical evidence meets the individual agency's standards for evidence.

Definition

Evidence-based practices for transition-age youth are interventions that have been shown scientifically to reduce or eliminate symptoms of mental illness, or to improve outcomes for people with mental

Definition (cont'd)

health problems. Criteria for the identification of EBPs vary across studies and organizations; however, the use of experimental or quasi-experimental studies to demonstrate efficacy is a hallmark of this approach.

Because this Tool Kit focuses on TAY full service partnership programs, it identifies interventions that are considered "mental health treatments" (as opposed to "mental health promotion") and programs for youth (ages 18–25). The NREPP is intended to be used as a "decision support tool." These interventions are scored by independent raters on several dimensions, and the scores are listed on the NREPP website.

Agencies and organizations should examine the information presented in the NREPP to determine whether an intervention achieves three benchmarks:

- Its scores meet agency standards for efficacy and readiness for dissemination with specific populations.
- It is directed at target outcomes identified by the organization or community.
- It is appropriate to the individual needs of transition-age youth.

Implementation Strategies

- Identify interventions for which at least one study validates their use with a specific group, ascertained by an "Advanced Search" conducted on the NREPP database, using the following search criteria: mental health treatment, age 18–25. Results are presented by ethnic or racial group. (A second category that is presented includes only those interventions that were tested with groups composed of more than 50% of the target population.)

Evidence-Based Practices for American Indian/Alaska Native Transition-Age Youth (Ages 18–25)
Acceptance and Commitment Therapy (ACT): http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=191
Celebrating Families!: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=100
Dialectical Behavior Therapy: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=36
Eye Movement Desensitization and Reprocessing: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=199
ICCD Clubhouse Model: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=189
OQ-Analyst: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=22
Trauma Recovery and Empowerment Model (TREM): http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=158
Interventions tested with 50% or more of the population selected: None

Implementation Strategies (cont'd)

Evidence-Based Practices for Latino/Hispanic Transition-Age Youth (Ages 18–25)
Acceptance and Commitment Therapy (ACT): http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=191
Celebrating Families!: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=100
Child-Parent Psychotherapy (CPP): http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=194
Dialectical Behavior Therapy: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=36
Emergency Room Intervention for Adolescent Females*: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=33
Eye Movement Desensitization and Reprocessing: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=199
ICCD Clubhouse Model: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=189
OQ-Analyst: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=22
Pathways' Housing First Program: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=155
Psychoeducational Multifamily Groups: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=120
Seeking Safety: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=139
Surviving Cancer Competently Intervention Program: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=154
TeenScreen: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=150
Trauma Recovery and Empowerment Model (TREM): http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=158
Interventions tested with 50% or more of the population selected

Implementation Strategies (cont'd)

Evidence-Based Practices for Black/African American Transition-Age Youth (Ages 18–25)
Acceptance and Commitment Therapy (ACT): http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=191
Celebrating Families!: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=100
Child-Parent Psychotherapy (CPP): http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=194
Dialectical Behavior Therapy: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=36
Eye Movement Desensitization and Reprocessing: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=199
ICCD Clubhouse Model: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=189
JOBS Program: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=170
Moral Reconation Therapy*: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=34
OQ-Analyst: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=22
Pathways' Housing First Program: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=155
Prolonged Exposure Therapy for Posttraumatic Stress Disorders: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=89
Psychoeducational Multifamily Groups: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=120
Seeking Safety: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=139
SITCAP-ART: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=195
Surviving Cancer Competently Intervention Program: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=154

Implementation Strategies (cont'd)

TeenScreen: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=150
Trauma Affect Regulation: Guide for Education and Therapy (TARGET): http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=104
Trauma Recovery and Empowerment Model (TREM)*: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=104
Interventions tested with 50% or more of the population selected

Evidence-Based Practices for Asian Transition-Age Youth (Ages 18–25)
Acceptance and Commitment Therapy (ACT): http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=191
Child-Parent Psychotherapy (CPP): http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=194
Dialectical Behavior Therapy: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=36
ICCD Clubhouse Model: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=189
OQ-Analyst: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=22
Psychoeducational Multifamily Groups: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=120
Seeking Safety: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=139
Surviving Cancer Competently Intervention Program: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=154
Interventions tested with 50% or more of the population selected: None

Evidence-Based Practice for Native Hawaiian/Pacific Islander Transition-Age Youth (Ages 18–25)
OQ-Analyst: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=22
Interventions tested with 50% or more of the population selected: None

Culturally Adapted Evidence-Based Practices

Purpose

To convey information to counties regarding evidence-based practices (EBPs) that have been culturally adapted to improve their effectiveness and acceptance by diverse communities.

Definition

Culturally adapted evidence-based practices constitute one approach by which to improve access to and quality of care for ethnic minority communities. Culturally adapted EBPs render practices more acceptable and more culturally congruent for a specific group. Cultural adaptations can include changing or enhancing the method of delivery – for example, conducting the treatment in the primary language of the clients, translating constructs and forms, ethnically matching providers with clients, and using cultural traditions or customs to illustrate therapeutic concepts. Other cultural adaptations include changing

Definition (cont'd)

the content of the intervention to include culturally relevant topics – for example, the impact of racism, discrimination, or acculturation. [32] Given that one of the hallmarks of EBPs is the use of empirical methods to determine efficacy, cultural adaptations should be enacted only after empirical study has produced evidence supporting the effectiveness of the modifications.

Example of a Culturally Adapted Evidence-Based Practice

GANA (Guiando a Niños Activos): *GANA* is a cultural adaptation of parent-child interaction therapy, an evidence-based program that improves parent-child relationships, increases parenting skills, and improves child behaviors. The GANA program entails several modifications to treatment, including a flexible approach, increased emphasis on engagement through phone contact, a focus on rapport building, and substitution of culturally acceptable terms such as *maestro* for "therapist" and *ejercicios de comunicacion* for "child-directed interaction."

32 Sue, S., Zane, N., Nagayama Hall, G., & Berger, L. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60,* 525–548.

Culture-Specific Interventions

Purpose

To provide information to FSP programs regarding culture-specific treatments or interventions created for a specific cultural group.

Definition

One way to improve access to and quality of care for ethnic minority communities is to develop discrete treatments or interventions for a specific group. Such *culture-specific interventions* generally accommodate the cultural values, norms, and traditions of the target group, by incorporating strategies that emerge from the cultural perspective of this group. These interventions differ from community-defined practices in that they have been studied through experimental methods and found to be efficacious. Some may overlap with the evidence-based practices listed in the "Evidence-Based Practices" tool.

Definition (cont'd)

Examples of Culture-Specific Practices

Family effectiveness training: Family effectiveness training combines bicultural effectiveness training – an intervention that focuses on reducing cultural conflict and acculturation stress within families – with brief strategic family therapy. Originally developed to reduce conduct problems in Cuban American adolescents, this treatment has been adapted for Latinos of other countries of origin. It addresses problems with family functioning and cultural conflict between parents and children, and results in reduced disruptive behaviors in children and improvements in family functioning.

Cuento therapy: Cuento therapy is a therapeutic modality aimed at reducing mental health problems and improving school achievement for children and youth. Originally developed for Latino children, it uses traditional stories as a cultural context for discussion of psychological issues.

Nia: The Nia intervention is designed to improve mental health, reduce suicidal ideation, and reduce exposure to domestic violence for African American women. It uses psychoeducation and support groups.

Community-Defined Practices

Purpose

To assist counties in identifying, supporting, and integrating community-defined practices (CDPs) into the range of mental health services available to clients, families, and communities. Community-defined practices hold the promise of improving access to, retention in, and quality of services for unserved, underserved, and inappropriately served ethnic and cultural groups.

Definition

Community-defined practices are "a set of practices that communities have used and determined to yield positive results as determined by community consensus over time, and which may or may not have been measured empirically but have reached a level of acceptance by the community" (Martínez, 2008). The term "practice-based evidence" sometimes is used in reference to CDPs. A community-defined practice

Definition (cont'd)

may be a specific treatment, or CDPs may consist of a set of interventions and activities, particularly in full service partnership programs. These interventions may include strategies to conduct outreach and/or to engage and build relationships with clients, families, and communities.

The majority of essential elements and typical characteristics of community-defined practices are contained within the set of practices that comprise the CDP, while some are characteristics of the organization that implements the CDP.

Essential Elements of Community-Defined Practices

Cultural relevance: Organizational practices and community-defined practices are specific to and reflect the cultural values, norms, and goals of the community.

Immersion in the community: Organizational practices and/or specific community-defined practices are characterized by ongoing community participation in most or all phases of program development and implementation, including:

- Assessment of community mental health needs in a manner that is aligned with community culture and values.
- Planning and program development, including identification of outcomes.
- Implementation of the program, which includes hiring staff members who live in the community and embrace the values of the community.
- Development of evaluation strategies and outcome measures.
- Implementation of the evaluation, a process in which community members participate in development of surveys, conduct focus groups and interviews, and contribute in other ways.

Definition (cont'd)

- Communication of information as part of a commitment to ensure that activities conducted by the organization are characterized by transparency. Information dissemination should be bidirectional. The organization should solicit comments, criticisms, and suggestions from the community and involve community members in decision-making processes, and it should deliver information to empower communities with knowledge about activities and progress. Strategies may include, but are not limited to, community educational forums, focus groups, and newsletters.

Access: Organizational practices and specific community-defined practices address barriers to access, such as language and cultural impediments, lack of transportation, stigma, caregiver concerns, financial insufficiencies, fear of deportation, racism or homophobia, and prior negative experience with social service systems. Strategies include but are not limited to: 1) conducting services in the primary language of the client served or providing appropriate interpreting services; 2) offering services in a location that avoids stigma and is accessible, welcoming, safe, and acceptable to community members.

Program articulation: Community-defined practices are characterized by a clear rationale for the selected strategies and interventions, which are defined and articulated sufficiently for replication by other communities.

Evidence: Community-defined practices are validated by evidence of their effectiveness in improving the mental health of clients in the target community. Strategies may include, but are not limited to, case studies, qualitative evaluations (such as focus groups and interviews), satisfaction surveys, small research studies, community consensus, and community-based support and endorsement.

Definition (cont'd)

Typical Characteristics of Community-Defined Programs

Outreach and engagement: The mental health services organization has clear and effective strategies for conducting outreach to the community and for engaging community members in accessing services by means of the chosen community-defined practices.

Mental health education: The organization has developed culturally responsive and appropriate education materials and/or tools to increase the community's understanding of mental health and mental illnesses, and has implemented culturally appropriate strategies to engage and inform the target ethnic group.

Community relationships: The organization has an established history of strong, constructive relationships with the community served, and of maintaining bidirectional communication.

Feedback and responsiveness: The organization periodically solicits comments and suggestions from the community to inform quality improvement processes and to ensure continued relevance of services for the community served. Services performed under the community-defined practices umbrella are characterized by flexibility and responsiveness to changing community needs.

Community workforce: A large portion of staff members and providers are community members – people who were raised and/or are living in the community served, or individuals who identify culturally with the community served.

Attention to culture-specific variables: "CDPs are more likely to take into consideration [culture-specific experiences] including historical trauma; current trauma related to racism/ethnocentrism/White privilege; worldview; immigration status; generation in the United States; preferred language; socioeconomic status; and the presence and practice of traditional beliefs, values, and rituals, including spirituality and communication styles."[33]

33 Martínez, K. (2008, Fall/Winter). Culturally defined evidence: What is it? And what can it do for Latinas/os? *El Boletin* (Newsletter of the National Latina/o Psychological Association).

Implementation Strategies

- Build partnerships with community organizations including but not limited to community-based organizations (e.g., faith-based, religious or spiritual entities, local news media outlets, social service providers, immigrant and refugee programs, and cultural centers), school districts, college campuses, community leaders, cultural brokers, practitioners of alternative healing, and community members through ongoing outreach, education, dialogue, and services.
- Explore creative ways to support and fund community-defined programs to encourage development new partnerships with underserved communities. Strategies include but are not limited to sole-source contracts and memoranda of understanding. In addition, counties may consider developing RFPs that take into account the unique assets of community-based organizations as well as the differences in infrastructure and resources for grant writing.
- Help build capacity in community-based organizations by offering technical assistance in areas identified in partnerships between the county and community-based organizations. Topics may include: grant writing, evaluation, and program sustainability.
- Foster partnerships between community-based programs and research institutions, local business partners, local political partners, private foundations, or county programs to enhance organizations' capacity to conduct evaluation, to obtain funding, and to ultimately improve program sustainability.
- Solicit information through interviews or focus groups with community leaders and community members regarding existing community assets and programs. To obtain this information, counties may ask:

Implementation Strategies (cont'd)

- Where would individuals in this community most likely go when they need help?
- How can the county or other funding agencies support these practices?
- What adjustment (if any) should be made in the current service provision criteria to support and ensure the success of these practices?

Note: For the purpose of this tool, "community" refers to a group of individuals with shared experiences, culture, and values that have a significant influence in their day-to-day activities.

Resource Guide

Each of the tools listed below has specific resources that you can locate in the general resource section on pages 129–130. This guide enables you to focus on the pertinent resources linked directly to each tool.

Name of Tool	Resource Number(s)
Overview of Specific Practices	3,4,7,8
The National Registry for Evidence-Based Programs and Practices (NREPP)	11
Evidence-Based Practices for TAY	11
Culturally Adapted Evidence-Based Practices	2,5,6
Culture-Specific Interventions	1,9,10
Community-Defined Practices	4

Resources

✔ Articles

1. Costantino, G., Malgady, R. G., & Rogler, L. H. (1986). Cuento therapy: A culturally sensitive modality for Puerto Rican children. *Journal of Consulting and Clinical Psychology, 54*(5), 639–645.

2. Huey, S. J., & Polo, A. J. (2008). Evidence-based psychosocial treatments for ethnic minority youth. *Journal of Clinical Child and Adolescent Psychology, 37*(1), 262–301.

3. Lau, A. S. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical Psychology: Science and Practice, 13,* 295–310.

4. Martínez, K. (2008). Culturally defined evidence: What is it? And what can it do for Latinas/os? *El Boletin* (Newsletter of the National Latina/o Psychological Association), Fall/Winter.

5. Sue, S., Zane, N., Nagayama Hall, G., & Berger, L. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60,* 525–548.

✔ Book

6. Griner, D., & Smith, T. B. (2006). Culturally adapted mental health interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training 43*(4), 531–548.

✔ Report

7. U.S. Surgeon General. (2001). *Mental health: Culture, race, and ethnicity. A supplement to mental health: A report of the surgeon general.* Office of the Surgeon General, Center for Mental Health Services, National Institute of Mental Health. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from http://www.surgeongeneral.gov/library/mentalhealth/cre/sma-01-3613.pdf

✔ Websites

8. California Reducing Disparities Project (CRDP), California Department of Mental Health Office of Multicultural Services: http://www.dmh.ca.gov/Multicultural_Services/CRDP.asp

9. Family effectiveness training (FET), from Family Therapy Training Institute of Miami: http://www.bsft-av.com/other-programs-a-services-/about-fet.html

10. Nia Project: http://www.niaendingviolence.org.uk/

11. Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices: http://nrepp.samhsa.gov/AboutNREPP.aspx

Appendix A

General Resources

✔ Articles

1. Carrasco, M. (2011). *Recent research: Meeting the mental health needs of the GLBT community.* [NAMI Blog post]. National Alliance on Mental Illness. Retrieved from http://blog.nami.org/2011/01/recent-research-meeting-mental-health.html

2. Courtney, M. E., Hook., J. L., & Lee, J. S. (2010). *Distinct subgroups of former foster youth during young adulthood: Implications for policy and practice.* Chapin Hall at the University of Chicago. Retrieved from http://chapinhall.org/sites/default/files/publications/Midwest_IB4_Latent_Class_2.pdf

3. Furstenberg, F. F. (2006, March). *Diverging Development: The not-so-invisible hand of social class in the United States.* Network on Transitions to Adulthood Research Network working paper presented at the biennial meetings of the Society for Research on Adolescence, San Francisco, CA. Retrieved from http://www.transad.pop.upenn.edu/downloads/invisiblehand_final.rev.pdf

4. Goode, T. D., Jones, W., & Mason. J. (2002). *A guide to planning and implementing cultural competence organizational self-sssessment.* Washington, DC: National Center for Cultural Competence, Georgetown University Child Development Center. Retrieved from http://nccc.georgetown.edu/documents/ncccorgselfassess.pdf

5. Greig, R. (2003). Ethnic identity development: Implications for mental health in African American and Hispanic adolescents. *Issues in Mental Health Nursing, 24,* 317–331. doi:10.1080/01612840305278

6. Huey, S. J., & Polo, A. J. (2008). Evidence-based psychosocial treatments for ethnic minority youth. *Journal of Clinical Child & Adolescent Psyhology 37*(1), 262–301. doi:10.1080/15374410701820174

7. Trainor, A. A. (2010). Adolescents with disabilities transitioning to adulthood: Implications for a diverse and multicultural population. *The Prevention Researcher, 17*(2). Retrieved from http://www.gucchdgeorgetown.net/data/documents/Trainor_Adolescents%20with%20Disabilities.pdf

8. White, C. R., Havalchak, A., Jackson, L., O'Brien, K., & Pecora, P. (2007). *Mental health, ethnicity, sexuality, and spirituality among youth in foster care – Findings from the Casey Field Office mental health study.* Casey Family Programs. Retrieved from http://casey.org/Resources/Publications/MentalHealthEthnicitySexuality.htm

✔ Fact Sheet

9. Swesey, M. (2008). *Evidence-based practices and multicultural mental health* [white paper]. Arlington, VA: National Alliance on Mental Illness (NAMI) Multicultural Action Center. Retrieved from http://www.nami.org/Template.cfm?Section=Fact_Sheets1&Template=/ContentManagement/ContentDisplay.cfm&ContentID=63974

✔ Reports

10. Calvin, E. (2010). *My so-called emancipation from foster care to homelessness for California youth.* New York, NY: Human Rights Watch. Retrieved from http://www.hrw.org/en/reports/2010/05/12/my-so-called-emancipation-0

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Appendix B

Introduction to Example Programs of Community-Defined Practices

To further illustrate the construct of community-defined practices, the CDP subcommittee (organized under the California Institute for Mental Health's Full Service Partnership Advisory Committee) identified five programs that would serve as "example programs." These CDPs were nominated by subcommittee members and were selected by consensus. Although the list of practices does not constitute a comprehensive survey of CDPs, it identifies a few example practices selected to epitomize the different types of practices that are being developed and implemented successfully by and for underserved communities.

The representative agencies and community-defined practices selected are:

1. Asian Pacific Family Center East: IMPACT! – A Youth Development and Leadership Program
2. Beats, Rhymes, and Life: Rap Therapy for TAY of Color
3. Latino Health Access: Promotor Program
4. Sacramento Native American Health Center: Warrior Down Program
5. Transcultural Wellness Center

As is evident from the program descriptions, these practices demonstrate the range of approaches utilized in communities. They also illustrate a common aspect of community-defined programs: while a few of these practices (such as Warrior Down or Rap Therapy for TAY of Color) consist of single interventions, the majority of these practices encompass a set of interventions embedded within a comprehensive community defined *program.* Central to the success of many of these programs is their implementation by a community-based organization that

has an established and constructive relationship with the community and that conducts outreach and engagement activities.

Concurrent with the California Institute for Mental Health (CiMH) process, the California Department of Mental Health (DMH) Office of Multicultural Services began implementing its California Reducing Disparities Project (CRDP).[34] A central objective of this project is to fund strategic planning workgroups (SPWs) to "identify population-focused, culturally competent recommendations for reducing disparities in mental health services, and seek to improve outcomes by identifying community-defined, strength-based solutions and strategies to eliminate barriers in the mental health systems."[35] The SPWs entered the final stage of their work in early 2012; by March 2012 several had released reports for public comment. These reports include a list of community-defined practices. California Reducing Disparities Project administrators and SPW members hope that the studies, definitions, and examples of CDPs that CiMH compiled for this report will complement the efforts of the DMH SPWs, and that in combination, these efforts will foster implementation and dissemination of effective community-defined practices.

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Asian Pacific Family Center East: IMPACT! – A Youth Development and Leadership Program

Program Overview

Housed in the Asian Pacific Family Center East in eastern Los Angeles County, the IMPACT! program is a 26-week intervention designed to empower Asian immigrant youth and help them build self-esteem. The program serves the San Gabriel Valley cities of Diamond Bar and Walnut, along with unincorporated areas including Hacienda Heights and Rowland Heights. IMPACT! (an acronym for Inspire and Mobilize People to Achieve Change Together) uses a culturally competent, age-appropriate, and interactive life-skills curriculum to support Asian immigrant youths in their development of goal setting, effective communication, problem solving, and other functional skills. It also addresses substance use and HIV to facilitate peer refusal skills development, and explores peers, family, culture, and other relevant topics to enhance prosocial life choices.

CDP Essential Elements

Cultural relevance

IMPACT!'s participants are youth who have moved to the United States within the past five years and are dealing with the stress of adapting to a new environment, culture, and language. Many participants report feelings of incompetence and social isolation, insufficient family support, a lack of school connectedness, and language barriers, in addition to the "normal" stress of adolescent development and the high academic expectations and pressures their families exert on them. The IMPACT! program is culturally relevant in that it addresses difficulties directly related to culture and acculturation stresses. IMPACT! works with students to help decrease isolation, to develop skills and strategies to cope with adapting to a new culture, and to improve family and school connectedness.

Immersion in the community

The IMPACT! Program is embedded in the Asian Pacific Family Center (APFC), which is closely connected to the community served. The APFC disseminates a bilingual newsletter, hosts community recreational events, and solicits comments and suggestions about its programs through focus groups. In addition, many APFC staff members live in the surrounding community. The APFC continually seeks ways to improve the effectiveness of IMPACT! and its other programs through five operational functions:

1. **Assessment:** To assess the needs of youth in the community, the APFC conducted focus groups at the initial stages of program development. The organization formed an advisory council, which includes youth members, to perform ongoing assessment of present and evolving community needs. Recommendations by the advisory council influence program modifications. Rocco Cheng, former IMPACT! program director and now corporate director of prevention and early intervention services, states, "We actively solicit input from our parents, youth, schools, and ethnic associations for advice on what is needed in the community – and what is not. They are our eyes and ears, keeping us tuned in to what works and where gaps are." One adaptation based on suggestions from the community has been expansion of the target population to include not only recent immigrant students but also students of immigrant parents, accompanied by expanded emphasis on the importance of bicultural competence.

2. **Planning and program development:** The IMPACT! program was developed to respond to the needs identified through the planning process. One such area of need that community members identified was the incidence of family and cultural conflicts beyond the scope of "normal" family conflict. These problems are rooted in parental expectations and pressure based on sacrifices parents make to move to a new country, and on youths' feelings of being overwhelmed and perhaps resenting that burden. In response to those conflicts, the program developed sessions on family communication, bicultural competence, and structured family activities to enhance and strengthen familial relationships.
3. **Implementation of programs:** The IMPACT! program is conducted by providers primarily from the local community. In addition, based on comments and suggestions from youths and other community members, another program called CATALYST (Community Alliance To Advance Leadership and Yield Social Transformation) was created. After students complete the IMPACT! program, they have the option to continue onto CATALYST, which focuses primarily on community service and allows youths to practice and apply many of the skills that they learned in IMPACT!
4. **Development of evaluation strategies:** Evaluation strategies primarily utilize standardized outcome measures. However, focus groups and other qualitative approaches ensure that the community voice is captured in the evaluation of the program.
5. **Communication:** Schools, libraries, businesses, and other organizations show support by promoting programs and materials via websites, display boards, newspapers and other communication media. The APFC also disseminates information and outcomes of the program through its bilingual newsletter.

Access

With a welcoming environment, the center has established constructive relationships with the community, characterized by ongoing bidirectional communication and participation. Access to the program is enhanced by performing services in schools and in the primary language of each student. APFC has a long-standing relationship with the three local school districts and is often called upon to assist in translation, cultural broker activities, and crisis response. In addition, the APFC hosts community events such as parent and family workshops at many of the local schools and community organizations. In 2011 the APFC hosted its first Be Connected – Family & Community Day event, at which families gathered for informative workshops, fun activities, and a resource fair.

Program articulation

The IMPACT! program is based on a 26-week curriculum that encompasses communication skills, problem solving, substance abuse, family and cultural issues, and other relevant topics.

Evidence

A randomized control study that EMT Associates, Inc., independently conducted as a program evaluation function suggested that youth who received the intervention had better outcomes than those in the control group. In addition, comments and suggestions from focus group participants indicate that community members find the services to be invaluable to the overall well-being and success of their children and family. IMPACT! contributes to aspects of youth development that may easily be overlooked by schools, after-school tutoring centers, and other providers.

Typical Characteristics of Community-Defined Programs

Outreach and engagement

The organization distributes a bilingual newsletter, hosts community events, and employs staff from the community. The APFC's partnerships with other service providers, schools, and law enforcement officials ensure that other agencies are aware of the IMPACT! program.

Mental health education

IMPACT! instructional programs teach coping skills such as time, stress, and anger management, conflict resolution, and problem solving. These skills equip youth to tackle some of life's challenges. In addition, the APFC staff participates in several community health and information fairs throughout the year, where they set up informational booths. APFC staff members also attend monthly community forums and collaborative meetings, to exchange information with other community stakeholders about mental health, and to disseminate information about APFC resources and services.

Community relationships

The organization partners with several local school districts, offering multiple programs and services at many of the elementary, middle, and high schools. The organization additionally is an active participant in several local community collaborative meetings, and works closely with several law enforcement agencies, and with many Chinese and Korean local community civic and parenting organizations.

Feedback and responsiveness

As the needs in the community increased and resources decreased, the program expanded its target group to include middle school students, and shifted from school-based to office-based operations in order to allow more students to access the services.

Community workforce

The IMPACT! program providers are of Asian background, many are bilingual, and many come from the community served.

Attention to culture-specific variables

Experiences specific to life as an immigrant youth are central to the content of IMPACT!'s program. The program helps participants confront social isolation, difficulty maintaining constructive relationships with family members, and inadequate connections with school. Program modules identify differences between the youth's culture of origin and culture in the U.S., the difficulties encountered in navigating different cultures at home and at school, and strategies for developing bicultural competence. While exploration and discussion of issues constitute the primary focus, communication, problem solving, conflict resolution, and other techniques that are taught in other parts of the curriculum are linked as an application.

Beats, Rhymes, and Life: Rap Therapy for TAY of Color

Program Overview

Based in Oakland, California, Beats, Rhymes, and Life (BRL) grew in response to a critical need for more youth-centered, strength-based, culturally responsive therapeutic programs for youth of color. In 2004 Tomás Alvarez III, a social worker and BRL founder, conceived an innovative Rap Therapy model in which underserved and inappropriately served teens become engaged in mental health services through the process of creating rap music. Over the years, BRL has grown from a single Hip-Hop Therapy program into a community-based, nonprofit 501(c)(3) organization composed of social workers, artists, educators, activists, therapists, community members and youth – all dedicated to improving health and social outcomes among youth and young adults of color. BRL's Rap Therapy program has been accredited as one of the first programs of its kind anywhere in the nation, and has laid the foundation for the development of other BRL programs and strategies for engaging and partnering with diverse youth communities. With therapeutic and youth development programs in Oakland, San Francisco, and Ashland, California, and South Bronx, New York, Beats, Rhymes, and Life is blazing a trail, demonstrating what is possible when community-defined solutions are used to promote individual and community wellness.

CDP Essential Elements

Cultural relevance

BRL places cultural relevance at the center of its three-pronged approach by utilizing popular cultural elements as primary vehicles for therapeutic work. Specifically, hip-hop culture and media arts form the cornerstone of BRL's approach. Because of the importance of hip-hop music and media arts to African American, Latino, and Asian/Pacific Islander youth as well as to youth of other ethnicities, BRL's approach enables the organization's staff to connect with youth, engage them in services, employ a youth-centered approach that promotes leadership, build upon strengths, and facilitate therapeutic self-expression through music and multimedia projects.

Immersion in the community

BRL has ensured its immersion in the community by locating its practices in local schools and community centers, and by engaging in extensive outreach through dissemination of youth-produced music, social media, video projects, news media, and events. To aid dissemination efforts, BRL has developed a host of websites, including a site about the organization itself, a music site, and an online store. In addition, BRL youth and staff have created documentary films, media campaigns, and music recordings that are available to the public through their website and portal sites. The organization's staff is involved in mental health promotion at statewide and national levels, through dissemination of programs nationwide, and membership on committees and work groups. BRL continually seeks ways to improve the effectiveness of its programs through five operational functions:

1. **Assessment:** By providing opportunities for youth to tell their story in ways that make sense to them, BRL gains important insight into specific needs and unique challenges faced by youth of color. BRL has worked with its youth participants to develop and adapt assessment tools that focus on strengths and opportunities as well as deficits and other problems.

2. **Planning and program development:** BRL's youth-centered approach places youth in the planning and program development process. BRL youth have been instrumental in aiding the expansion and development of new BRL programs, including BRL's Let's Chat – a program created to diminish the prevalence of pregnancy among teenagers – and BRL Academy youth leadership development programs.
3. **Implementation of programs:** BRL strives to function as a staffing partner that reflects the racial and cultural composition of its target population. As of early spring 2012, five of BRL's six staff members are people of color, and four out of six are male. BRL initiated efforts to create a "pipeline" program for alumni of its Rap Therapy program. Five African American youth (four males and one female) participate in an academy in which they learn how to co-facilitate the Rap Therapy program. The vision of BRL Academy is to create a pipeline to the helping professions for youth of color as a means of responding to workforce disparities that discourage youth from accessing services.
4. **Development of evaluation strategies:** BRL's Rap Therapy program has been the focus of two empirical studies, and BRL is working with the Alameda County Health Care Services Agency to develop and implement outcome measures across all of its programs.
5. **Communication:** BRL disseminates information about programs and program outcomes through documentaries, news media, social media, conferences, and through production of music and movies. Youth gain confidence through the process of public dissemination of information about content that they and other TAY create. BRL empowers youth to speak on behalf of themselves and their peers, reinforcing BRL's philosophy of "co-creating efficacy" among TAY and their communities.

Access

To ensure easy access for youth in the community served, BRL has embedded its programs in school and community organizations, and uses an approach that is strength-based and culturally relevant to TAY, particularly youth of color. Programs are underwritten mostly through a diverse funding model that includes subsidies from the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, county contracts, foundation grants and in-kind support. All programs are offered in English but accommodate people who speak other languages. For example, participants in BRL's Let's Chat program created a video public service announcement on teen pregnancy awareness for Spanish-speaking parents and uploaded it to YouTube (http://www.youtube.com/watch?v=me1EqOMfsR4&list=UUs2TAEGPvBBatJyagyXJ0vw&index=4&feature=plcp).

Program articulation

Based on principles of narrative therapy, BRL's Rap Therapy program helps youth explore and evaluate their life narratives and their emotions. In the program, youth write rap music about their experiences, perform the rap for an audience of peers, facilitators, and therapists, and receive critiques from the group. BRL has disseminated program strategies through its website, by means of documentaries broadcast on radio, in print news media, and in a book: Therapeutic Uses of Rap and Hip-Hop, edited by Susan Hadley and George Yancy, with contributing author Tomás Alvarez III (2011, London, England: Routledge and Psychology Press). BRL has offered its Rap Therapy program through two school-based health centers. In each case the program has served as a point of access to other health and wellness services.

Evidence

The BRL Rap Therapy program has been the focus of two empirical studies, both of which reported positive outcomes. Among them were rates of attendance and retention greater than

90%, along with increases in self-efficacy, self-confidence, coping skills and constructive peer interactions. Many youth who complete BRL's Rap Therapy program express a desire to remain connected to the program and organization. Five alumni of the Rap Therapy programs serve as interns in the BRL Academy, while four more youth are on a waiting list.

Typical Characteristics of Community-Defined Programs

Outreach and engagement

In addition to BRL's active use of social media, news media, documentary films, and youth-created musical productions as means of publicizing its programs, BRL has developed strong relationships with community and institutional partners. For example, BRL partnered with the Alameda County Health Care Services Agency to build the Ashland Youth Center, a community center that will provide a variety of services, including health and wellness instruction, recreational activities, mentoring, arts and culture programs, and job-seeking assistance. BRL will be one of five lead agencies to operate the center after its anticipated December 2012 completion.

Mental health education

BRL performs ongoing education, advocacy, and promotion of its efforts to embrace community-defined solutions and utilization of innovative program models.

Community relationships

BRL has established a presence in the community by forging a strong relationship with schools, community-based organizations, and systems of care, and by disseminating the products of the youths' work widely.

Feedback and responsiveness

BRL's three-pronged approach (youth-centered, strength-based, and culturally congruent) enables development of age-appropriate and relevant programming that youth have had the opportunity to shape and form. Over the years, BRL has expanded its Rap Therapy program model into a TAG (therapeutic activity group) model capable of utilizing numerous activities as a catalyst for change and development. The TAG model encourages flexibility in program development and has enabled BRL to pilot other therapeutic groups, including an online youth magazine TAG and a media arts TAG.

Community workforce

Many of BRL's staff members live in the communities in which they work or come from similar communities. They share some common experiences and are invested not only in serving youth but also in building the power of communities to help, heal, and grow themselves.

Attention to culture-specific variables

Through rap music, BRL participants explore events that relate to their lives and their communities. Many participants are African American youth who have experienced or witnessed violence in their families and neighborhoods, and face systems of oppression daily. Many have relatives or friends who have been threatened, harmed, or murdered as a consequence of these patterns of oppression. Participation in the group allows youth to tell their stories and explore the meaning of their experiences, as well as tap into and foster internal assets.

Latino Health Access: Promotor Program

Program Overview

The mission of Latino Health Access (LHA) is to assist in improving the quality of life and health of uninsured, underserved people through high-quality preventive services and educational programs that emphasize responsibility and full participation in decisions affecting health. Two significant approaches to the work at Latino Health Access are participation and empowerment. Needs identified through community assessment of conditions that compromise the health of residents are addressed through (1) educational health promotion programs to change individual and family health behaviors, (2) creation of awareness of the social determinants of health, and (3) fostering leadership and advocacy skills to create system change. A standout aspect of LHA and its role in the community is the use of promotores de salud – community health workers. Promotores and promotoras are LHA employees and community members who are able to teach and engage residents on a peer level. They speak the language of participants and understand impediments facing families served by LHA.

The Promotor Program at LHA has expanded to encompass many different aspects of health and mental health. Beginning with a diabetes program, LHA created an additional intervention in partnership with Orange County Health Care Agency's Behavioral Health Services focused on helping individuals who have mental illnesses such as schizophrenia and bipolar disorder in combination with chronic diseases. With the Children and Families Commission of Orange County, LHA trained families with children 5 years of age and younger in child development, substance abuse prevention, and overcoming lack of access to services. In partnership with the Academic Center for Prevention of Violence and the Centers for Disease Control and Prevention, LHA promotores were trained to implement an evidence-based intervention called Families and Schools Together (FAST). With clinical psychologists Dr. Cristina Jose and Dr. Lyndee Knox, LHA has developed an evidence-based curriculum titled "Madres a Madres" (mothers to mothers), which the organization began piloting and improving in 2011. Promotores have been trained in concepts of mental health, mental illness, prevention, brain development, human development, discipline, depression, violence, self-help and mutual help groups, crisis management, personal interviews, and other topics, in order to implement various mental health intervention components.

While this CDP refers to children, youth, and families, it also has been successful with the older adult population.

CDP Essential Elements

Cultural relevance

LHA's mental health programs focus on experiences central to life as a Latino immigrant in California.

Immersion in the community

involvement is pivotal to all aspects of program development, including needs assessments and development, implementation, and evaluation of interventions. LHA continually seeks ways to improve the effectiveness of its programs through four operational functions:

1. **Assessment, planning, and program development:** With the leadership of youth and adults, LHA personnel identified mental health, intra-family violence, lack of supervision, substance abuse, violence in teen dating, and depression as major issues affecting the community and deserving of intervention.
2. **Implementation of programs:** Trained promotores created and continue to (1) lead support groups on domestic violence and depression; (2) teach workshops; (3) carry out one-on-one interventions with participants; (4) conduct home visits; (5) organize retreats; (6) connect participants with services; and (7) support participants by referring them to transportation services, performing translation services, keeping them company, and offering advocacy while accompanying them to schools, medical office visits, and judicial system proceedings in courts. Our promotores are among the first line of contact in case of crisis within the families they serve. Promotores organize the community and build capacity among participants so they can learn to navigate systems and be independent.
3. **Development of evaluation strategies and outcome measures, and implementation of evaluations:** LHA partners with foundations and academic institutions to conduct evaluations. Promotores and promotoras are essential in the implementation of evaluation strategies.
4. **Communication:** LHA publishes a periodic newsletter and hosts an online portal for consumers and community members to access information regarding events and activities of the center.

Access

Program participants are first- and second-generation immigrants who have limited or no health insurance, and who face barriers to health care that include low reading levels, unfamiliarity with the health-care system, lack of proficiency in English, and traditional respect for physicians that inhibits them from asking probing questions. Promotores speak the same language, come from the same neighborhood and commonly share some life experiences with the community members they serve. By talking with the community members and valuing their concerns, the promotores gain the trust of clients, who are willing to allow program representatives to come to their homes. The Promotor Program also circumvents transportation-related barriers to care by delivering services at the participants' homes or other preferred locale, including parking structures, laundromats, apartment complexes, and living rooms. Promotores have been extremely innovative in forging collaborations with medical and social service providers because they offer reciprocal value, such as cultural competency learning opportunities. Donation of items and time by volunteers allows LHA to perform services at a low cost for uninsured clients.

Program articulation

The Promotores Programs are based on nationally recognized principles for community health workers. The mental health programs include specific modules and content that are based on the needs identified by the community as well as evidence-based interventions (such as parent-child interaction therapy).

Evidence

Promotores interventions have been recognized by news media outlets, including Newsweek and a PBS television documentary, FAT: What No One Is Telling You. LHA also has been recognized with various awards. In 2008, the Governor's Council on Sports and Fitness

Spotlight honored LHA as Nonprofit Organization of the Year Gold Medalist based on the Healthy Weight/Peso Saludable Program. In 2008 America Bracho, LHA's executive director and founder, was presented with the James Irvine Foundation California Leadership Award, and a communication grant to disseminate lessons learned using the promotor model. In 2009, the PBS program Bill Moyers Journal broadcast a segment about LHA's efforts to build a park and community center in the most park-deficient area of Orange County. A special piece featuring LHA's Madres a Madres program also can be found on the Bill Moyers Journal PBS website. A pilot study of the Madres a Madres program, being conducted in collaboration with the Southern California Center of Academic Excellence on Youth Violence Prevention, is investigating the experiences of 200 participating families in Santa Ana, California.

Typical Characteristics of Community-Defined Programs

Outreach and engagement

LHA is known for being resourceful, creative, and innovative in the ways it conducts outreach, delivers services, and engages partners. Promotores conduct outreach by visiting neighbors, offering engaging activities in areas with a high concentration of individuals, and conducting provocative campaigns. Promotores also conduct outreach by collaborating with community partners such as schools, churches, community clinics, private providers, the Mexican Consulate, social service agencies, family resource centers, self-help networks, 12-step programs, apartment managers, Latino markets, and the neighbors themselves. Families that have benefited from their involvement with LHA are excellent sources for referrals.

Mental health education

One of the primary goals of the Promotores Program at LHA is the education of community members about mental health, healthy behaviors and choices, signs and symptoms of mental illness, and resources for coping with mental health problems. LHA strives to build capacity within the community to respond to these problems by identifying community leaders and equipping them with the knowledge and awareness of mental health issues that affect their communities.

Community relationships

LHA has a longstanding presence in the community it serves and employs primarily community members in program leadership and implementation. This strong presence has enabled LHA to develop a relationship with the community based on trust and mutual support. LHA conducts community events intended to celebrate Latino culture as well as to increase awareness of LHA programs and mental health issues that affect the Latino community. These events include the Día de Los Muertos celebration and the annual Tamalada, in which community members cook and sell tamales. The proceeds of the Tamalada help to fund the involvement of promotores and promotoras in programs.

Feedback and responsiveness

The programs were developed based on the needs identified by the community. LHA continues to solicit comments and suggestions from the community through the voices of the promotores.

Community workforce

The Promotor Program staff identified individuals from the community who have the lived experience of overcoming obstacles and learning to cope with the health problem that LHA targets. Due to their in-depth knowledge and the needs of the community, several community members emerged as promotores for LHA's domestic violence and depression programs.

Attention to culture-specific variables

The Promotor Programs confront problems related to acculturation, cultural conflict within families, cultural differences between the culture of origin and culture in the U.S., and other variables specific to the immigrant experience. Because the providers typically have cultural backgrounds similar to those of clients, they share the cultural values such as personalismo, familismo, and respeto common in Latino communities. This correlation enables promotores and promotoras to build strong alliances with clients and the LHA to create lasting relationships with the community.

Sacramento Native American Health Center: Warrior Down Program

Program Overview

The Warrior Down Program is an intervention that the Sacramento Native American Health Center (SNAHC) operates as a means by which to prevent relapses and to conduct recovery support services for Native Americans who are completing treatment, returning to the community from incarceration, or who have been on their recovery journey using traditional methods or 12-Step Medicine Wheel teaching methods. Re-establishment of life following treatment for alcohol or substance abuse or following incarceration requires a community effort. Without the support of a knowledgeable family and community members, many people who try to resume healthy, productive lives find themselves frustrated by unfulfilled needs in job training, education, housing, transportation, mental health care or medical support, social services, spiritual and cultural support, or connections with others who value sobriety and healthful approaches to living.

"Warrior down" is the cry used to signify that a warrior has been wounded or incapacitated in some way and needs help. The Warrior Down Program involves weekly group meetings that include talking circles and traditional cultural and spiritual practices. The program uses a peer-to-peer approach that equips clients with the training and skills they need to offer support and community referrals for others in recovery.

CDP Essential Elements

Cultural relevance

For many Native American people the path to healing is found through traditional cultural and spiritual practices. Healing processes can include talking circles, healing circles, and traditional ceremonies. Ceremonial activities have a distinctly spiritual focus and incorporate intergenerational activities that include both elders and children in the healing process. These activities are essential for the well-being of men and women in Native American communities. The teachings of the elders and the clan mothers embody wisdom and guidance. The spiritual practices serve as pathways to meaning and purpose in life, and the cultural activities create a social and emotional foundation for reconnecting and reestablishing a sense of belonging and identity.

Culturally appropriate aftercare and re-entry programs at SNAHC give Native Americans opportunities to reconnect to their communities and to create a healthy life that reflects a balance emotionally, mentally, physically, and spiritually. SNAHC personnel call this a life of "wellbriety." The Warrior Down Program is one of the resources that can be used to help people achieve wellbriety as they re-enter the community following treatment or incarceration.

Immersion in the community

The Sacramento Native American Health Center Inc. (SNAHC) is a nonprofit 501(c)(3), federally qualified health center (FQHC) in downtown Sacramento. It is community-owned and operated, and governed by a nine-member, all-Native American board of directors. The health center's dedicated team of highly trained clinicians offers a wide range of services, including adult medicine, pediatrics, mental health services, laboratory services,

comprehensive dental care for children and adults, substance abuse services, community education and prevention services, nutrition and diabetes care, and home visitation services. BRL continually seeks ways to improve the effectiveness of its programs through five operational functions:

1. **Assessment:** SNAHC periodically facilitates community focus groups that aid in collecting data, analyzing, interpreting, and reporting the needs and interests of the Native American community in Sacramento. They also are instrumental in community problem solving and program evaluation.
2. **Planning and program development:** The focus groups that SNAHC conducts are intended to help participants gain a deeper understanding of the Native American community's views and experiences, and to serve as a forum in which to articulate their feelings and ideas about how the agency can improve service delivery or implement new strategies to assist them in achieving health and wellness.
3. **Implementation of programs:** The peer-to-peer approach of the Warrior Down Program ensures that clients form an important part of the support services offered. In addition, 72% of SNAHC staff members are from local and out-of-state tribes.
4. **Development of evaluation strategies and outcome measures, and implementation of evaluations:** The periodic meetings of focus groups allow the SNAHC to evaluate existing programs and to obtain critiques and suggestions directly from community members.
5. **Communication:** The SNAHC communicates with the community through meetings and events scheduled regularly at the center. Results of recent focus groups were shared with the community through a social gathering at the center.

Access

The SNAHC has a strong and constructive relationship with the Native American community in Sacramento, as well as with other minority groups. Community members serve in leadership positions (on the board), in provider positions, and in peer support positions. The SNAHC frequently hosts cultural and educational events, including the Family Gathering of Native Americans (described under the "outreach and engagement" segment, which follows). This relationship and contact with the community improves community members' willingness to access services at the center. SNAHC, based in downtown Sacramento, schedules appointments during and after regular business hours. The Warrior Down Program celebrates Native American culture and offers support in a non-stigmatizing, peer support group format.

Program articulation

The Warrior Down Program utilizes traditional and 12-Step Medicine Wheel teaching methods, as well as culturally relevant practices such as intergenerational participation and support, and drumming and other cultural practices.

Evidence

Commentary during focus group meetings indicates that the program is effective in promoting healthy lifestyles and preventing relapse, and that community members are satisfied with the outcomes.

Typical Characteristics of Community-Defined Programs

Outreach and engagement

SNAHC hosts numerous events annually, including a Prevention Health Faire, Recovery Day Celebration, and Family Gathering of Native Americans (GONA), held every summer. The center places priority on implementing cultural practices with the ultimate goal of reducing the prevalence of chronic disease, including heavy alcohol consumption, within the American Indian community. Warrior Down participants are encouraged to volunteer as a form of giving back to the community while their families participate in the events.

Mental health education

The HOPE (Healing Our People Through Education) class that SNAHC conducts focuses on life skills development and relapse prevention. Mental health issues are discussed as part of the curriculum to assist community members in recognizing symptoms to prevent drug and alcohol use. An SNAHC bipolar support group that meets weekly helps patients build a network of support with other community members to cope with life as a bipolar patient.

Community relationships

The SNAHC was founded by Native American community members, and its core staff and clients are Native American. SNAHC is active in supporting, sponsoring, and hosting community events that celebrate Native American culture and traditions.

Feedback and responsiveness

SNAHC strives to communicate frequently with community members to obtain their comments and suggestions. For example, within the past year SNAHC hosted a series of focus groups with Native American community members. Focus groups were divided into five age groups: 12–15, 16–18, 19–30, 31–55, and an elders panel. The results of the focus group were shared with the community at a social gathering at which a five-year plan was disclosed. One of the most repeated requests is for the continued use of cultural groups, classes, and events, especially for spiritual cleansing.

Community workforce

Since the grand opening of SNAHC, its staff has grown to meet the needs of the community; 72% of staff members are Native American from local or out-of-state tribes. The organization's goal is development of an experienced and capable Native American workforce composed of experts in their chosen fields.

Attention to culture-specific variables

SNAHC's Warrior Down Program and several of its behavioral health classes, as well as counseling and therapy, incorporate education regarding historical trauma. In the 1980s Dr. Maria Yellow Horse Braveheart conceptualized discussion of historical trauma as a way to develop stronger understanding of why the "American Dream" has been elusive for many Native Americans. Historical trauma encompasses cumulative emotional and psychological wounding over an individual's lifespan and across generations, emanating from massive group trauma.

For more than 500 years, Native Americans have endured physical, emotional, social, and spiritual genocide from European and American colonialist policy. History has proven that many great leaders of the tribes were ravaged and interned. These brave Native American

leaders did everything humanly possible in the face of the ongoing march of European American colonists across their land to protect their people and their way of life, sadly to little or no avail. They eventually saw countless genocidal violent acts perpetrated on their people and lands. Descendants of these early leaders to this day suffer the adverse effects of historical trauma grief, evident among members of the 583 tribes that the federal government recognizes. The effects of historical trauma include unsettled emotional trauma, depression, high mortality rates, high rates of alcohol abuse, and significant child abuse and domestic violence.

SNAHC is collaborating with community advocates, allies, teachers, and students of historical trauma with the objective of strengthening understanding of unresolved historical grief and developing a unified approach for healing these wounds. SNAHC offers community members an opportunity to learn or to pass along what the organization has learned about historical trauma experiences, prevention, intervention, and healing. Studies have shown that the historical trauma intervention approach yields significant reduction in anger, sadness, guilt, and shame. Several excellent Native American researchers have begun conducting research and creating instructional curricula that are beginning to create a more unified approach toward healing.

Transcultural Wellness Center

Program Overview

The Transcultural Wellness Center (TWC) is a full service partnership program that conducts mental illness recovery services for Medi-Cal-eligible or medically indigent Asian and Pacific Islander (API) clients and families. The TWC was created as a result of a stakeholder process that united diverse Asian/Pacific Islander providers, agencies, and community members in seeking mental health treatments and strategies that would benefit the various API groups in the Sacramento area. Psychiatrists, clinicians, and mental health counselors and recovery specialists from the targeted cultural communities perform services for TWC clients. Services are built around incorporation of TWC clients' cultural identities, beliefs, and practice with the goals of rediscovering hope, fostering meaningful relationships within clients' cultural communities, and empowering the clients in their relationship with the larger mainstream society.

CDP Essential Elements

Cultural relevance

The TWC staff helps clients define their personal vision of wellness, usefulness or meaningfulness, and healing. This process incorporates the cultural perspectives of clients, their family members, and the communities in which they are embedded. While TWC services include traditional psychopharmacologic, psychotherapy, psycho-education and social rehabilitation principles, the integration of our clients' cultural values and perspectives has led to novel approaches. TWC performs services in the clients' own language, or on rare occasions through use of a trained interpreter for clients from an API sub-culture that exceeds TWC's cultural and linguistic abilities. Some clients engage in western medication support services in combination with traditional healers such as spiritual leaders, shamans, herbalists, and acupuncturists. Psychotherapy services frequently are done as part of home visits at the request of clients who have limited access to transportation. These home visits also parallel the encounters that traditional healers may use in the country of origin.

Given the tremendous disruption of community caused by the military conflicts that many TWC clients have endured, as well as the stigma of mental health, the program has a strong focus on sociocultural rehabilitation. For example, many TWC clients have discussed the stress of being displaced from their country of origin to the United States, where the life skills with which they were raised have limited applicability. That displacement can result in feelings of uselessness, disconnection from the younger, more acculturated generations, and overall sociocultural isolation. In response to this phenomenon and at the request of clients, TWC developed client-driven activities such as a farming group in which clients and staff members who share similar cultural backgrounds explore ways of farming that incorporate mother country and mainstream methods. Each such adaptive approach serves as a framework for clients' ongoing work to preserve their cultural identities, values, and practices, while incorporating mainstream strategies and resources when applicable. Clients also participate in fishing groups, gender- and culture-specific support groups, and cultural celebrations hosted both at the agency and in the community.

Immersion in the community

TWC was built on a foundation of relationships with community members, leaders, and organizations. Participants in this diverse coalition came together to advocate for development

of a one-stop community resource that would respond to the unmet mental health needs of the API community in Sacramento. The process galvanized a community group to advocate at meetings of the Sacramento County Board of Supervisors and at the Sacramento County Department of Behavioral Health to voice the concerns of this community. Because of this foundation of community organizing, TWC has a strong presence and recognition in the API community. TWC continually seeks ways to improve the effectiveness of its programs through five operational functions:

1. **Assessment:** Early in 2012, the TWC program initiated a self-assessment process through client participation in interviews in which clients discussed their personal recovery as they participated in the program during the past year. The data gathered will help TWC assess its strengths and weaknesses of its program to enable the organization to make improvements in its services. TWC also works cooperatively with Sacramento County government personnel through performance outcome reports, surveys, and focus groups.
2. **Planning and program development:** In early 2012, TWC participated in client and community focus groups that the Sacramento County Department of Behavioral Health convened for the Vietnamese, Chinese, and Hmong communities. For the focus group meetings, TWC furnished interpreters for each language group. Clients participating in these focus groups were asked to describe how the services helped them, and to identify what problems they have encountered. Focus group participants also were asked what other kinds of services they would find helpful. Inclusion of TWC clients in these focus groups and assessments gives them a voice and sense of empowerment.
3. **Implementation and sustainability of programs:** The majority of TWC's staff is bilingual and bicultural, and is drawn from the communities served. The composition of the staff enables TWC to sustain its culturally and linguistically competent program and achieve the continued acceptance and trust from the community that the organization serves.
4. **Development of evaluation strategies and outcome measures, and implementation of evaluations:** TWC utilizes focus groups to obtain information about client needs and satisfaction, as well as to help ensure ongoing cultural and linguistic competence.
5. **Communication:** Asian Pacific Community Counseling APCC/TWC publishes a newsletter that informs the community, clients, and supporters about programmatic developments within the agency as well as relevant news within the community that the organization serves.

Access

Barriers to access are significant in the Asian and Pacific Islander communities. Many API clients are unaccustomed to mainstream mental health access points, such as the mental health intake line, with which traditional cultural pathways to treatment often differ. For example, a common Vietnamese pathway to healing involves speaking with pharmacists rather than physicians or case managers as the first point of contact. Likewise, many API members utilize kinship networks, spiritual leaders, and community organizations as entry points. TWC has engaged with several community partners that characterize the network of access for the cultural communities that API serves. The organization also helps the families of its clients resolve transportation barriers, and assists in connecting them with community and county resources, linguistic translation services, and cultural brokering as needed to enable them to gain access to services. TWC encourages spiritual connectedness, and coordinates services with traditional healing and spiritual rituals as desired by the client. APCC/TWC coordinates services with several Sacramento community agencies, including the Hmong Woman's Heritage Association, Asian Resources, Southeast Asian Assistance Center, My Sister's House, and TOFA (To'utupu'o e'Otu Felenite Association).

TWC, located within the API community, is accessible, culturally welcoming and comfortable. Because stigma concerns many clients, TWC helps them and their families feel accepted at the agency's functions, and encourages integration into the community through assisted and sponsored cultural programs and activities.

Program articulation

Not applicable. TWC is a comprehensive program that encompasses many interventions.

Evidence

The Sacramento County Department of Behavioral Health engages in annual program evaluations with TWC. The results of these evaluations indicate that the TWC program has been successful in reducing hospitalizations, emergency room and crisis visits, homelessness, and incarcerations.

Typical Characteristics of Community-Defined Programs

Outreach and engagement

The TWC staff participates regularly in community outreach activities appealing to the API communities through booths at community festivals and other events, and individually with families in their homes. Through such contact, the API staff is able to educate community members about mental illness and about resources available to them.

Mental health education

The psychoeducation programs that the staff conducts through participation in events and festivals inform community members about mental illness. API also assists in educating western medicine and mental health providers about API traditions and beliefs related to mental health and wellness.

Community relationships

TWC was formed by a community coalition and therefore began with a foundation of strong relationships with community members, leaders, and organizations. TWC coordinates services with community agencies – including the Hmong Woman's Heritage Association, Asian Resources, Southeast Asian Assistance Center, My Sister's House, and TOFA (To'utupu'o e'Otu Felenite Association) – and also partners with faith-based organizations and community groups, along with other traditional community resources.

Feedback and responsiveness

In order to continue meeting the needs of the API community, API recurrently assesses the programs now in practice and seeks to develop more services over time. From its outset, API has operated with the guidance of a community advisory council (CAC), made up of representatives from the communities that the organization serves. The CAC reviews program outcomes, suggests opportunities for improvements, and assists in linkages to additional community resources.

Community workforce

The majority of TWC staff members come directly from the Asian and Pacific Islander community, thereby giving them insights about the cultural values, history, beliefs, and needs of clients. This familiarity enhances client and family engagement and increases the likelihood of beneficial outcomes.

Attention to culture-specific variables

As TWC staff members work with each client and their family, they take into account the client's cultural and family history and experience as a refugee or immigrant. Many of the past experiences of clients may have been traumatic as they and their families began new lives in the United States. To be responsive to these physical, psychological, and sociocultural traumas, TWC staff members are particularly attentive to problems emanating from loss and transition, as well as existential concerns related to fate, survival, belongingness, and death. TWC providers are well versed in the psychological, social, and biological treatment of PTSD. TWC also conducts medical-psychiatric consultations and case conferences for clients who have poorly defined or unexplained physical problems that are common among people who have experienced trauma. In addition, the TWC staff has expertise in identifying and attending to adaptive paranoia, which is a natural cultural response among people who have been victimized by discrimination. The TWC staff collectively performs direct mental health services in 11 languages, incorporating multiple API worldviews into treatment collaborations with clients and their families.